

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F000000	<p>This visit was for the Investigation of Complaint IN00151653.</p> <p>Complaint IN00151653-Substantiated. Federal/State deficiencies related to the allegation are cited at F309.</p> <p>Survey date: July 1, 2014</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Surveyor: Heather Tuttle, RN-TC</p> <p>Census bed type: SNF 15 SNF/NF: 74 Total: 89</p> <p>Census payor type: Medicare: 16 Medicaid: 64 Other: 9 Total: 89</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 5,</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000309 SS=D	<p>2014, by Janelyn Kulik, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to monitor and assess non pressure ulcers according to the facility's policy and procedure for 1 of 3 residents reviewed for pressure ulcers. (Resident #B)</p> <p>Findings include: On 7/1/14 at 1:40 p.m., Resident #B was observed in bed. At that time, LPN #1 was to perform a skin assessment. The resident was rolled over to her right side. There were bandages noted on the resident's left and right gluteal folds and the resident's coccyx area. LPN #1 removed the resident's bandage to the left gluteal fold. The area was open and red, with a small amount of bloody drainage noted. The surrounding skin was red and</p>	F000309	<p>F-Tag 309 Provide Care/Services for Highest Well Being: It is the policy of Miller's Merry Manor, Hobart to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident B plan of care was reviewed and updated on July 3rd. New low air loss mattress placed on bed, discussed compliance with resident with turning/ repositioning program. All non pressure related wounds will be monitored weekly until resolved per policy. All residents with any non pressure wound alterations are at risk to be affected by the deficient practice. The DON and nurse managers completed head to toe skin assessments on all residents by</p>	07/09/2014

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	<p>there was evidence of a white cream noted.</p> <p>The right gluteal fold dressing was then removed. There was an open wound noted and the surrounding skin was purple/red in color. There was a moderate amount of bloody drainage noted on the bandage. Continued observation indicated the resident's brief was crumpled and wrinkled under the resident's right gluteal fold area.</p> <p>Interview with the resident at that time, indicated the areas were painful. She further indicated she did not wear a brief at night. The resident indicated she has had the areas for quite some time and was glad when they changed the treatment because the Calmoseptine was not working. The resident indicated "it feels better when I am lying down."</p> <p>The record for Resident #B was reviewed on 7/1/14 at 10:27 a.m. The resident was admitted to the facility on 5/12/12. The resident's diagnoses included, but were not limited to, Multiple Sclerosis (MS), neurogenic bladder, anxiety, paraplegia, anemia, and high blood pressure.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment dated 4/7/14</p>		<p>July 9th and all non-pressure wound alterations identified per facility policy will be followed weekly until resolved. HCP's for any resident identified with a non pressure wound issue has been updated. The facility has added a full-time treatment nurse for ongoing compliance. Treatment nurse has been inserviced on facility policies for skin/wound management. The corrective action will be monitored utilizing the QA tool "NonPressure Wound Assessment Review" (Attachment A). Tool will be completed daily for 1 week, then 3x weekly for (3) week, then weekly for (4) weeks, then monthly by the DON or other designee. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.</p> <p>Date of Compliance: July 9, 2014</p>				

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	<p>indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 indicating she was alert and oriented.</p> <p>The resident was an extensive assist with two person assist for bed mobility and was totally dependent for transfers and dressing with one person assist. The resident's weight was 196 pounds.</p> <p>Review of Physician Orders dated 4/14/14, indicated Calmoseptine (a topical cream used for irritated skin) apply to right posterior thigh twice daily.</p> <p>Review of the Treatment Administration Records (TAR) dated 4/14-4/30/14, 5/1-5/31/14 and 6/1-6/22/14 indicated the treatment was to be completed on the evening and night shift. Further review of the TARs indicated the treatment was being signed out as being completed on all of the above mentioned dates.</p> <p>Review of Physician Orders dated 6/23/14 indicated discontinue previous treatments. Start with Silvadene and dry dressing daily to right and left posterior thigh and coccyx daily and apply dry dressing daily.</p> <p>Review of the New Skin Alteration Findings dated 4/14/14 indicated "New rash/excoriation. Macerated incontinence</p>			

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	<p>associated dermatitis to right posterior thigh measuring .6 centimeters (cm) by 1.0 cm. Scant amount of serosanguineous drainage. Surrounding skin erythema and maceration."</p> <p>Review of the non pressure wound assessments for the months of April (after 4/14/14), May 2014, and up until 6/25/14, indicated there was no evidence the area to the right posterior thigh was assessed and monitored.</p> <p>Review of Nursing Progress Notes dated 4/15-6/23/14 indicated there was no evidence of any assessment or documentation of the resident's wound to her right posterior thigh.</p> <p>Review of the non pressure wound assessment sheet dated 6/25/14 indicated the location of the wound was the left gluteal fold. The area was classified as incontinence associated dermatitis. The area measured 3 cm by 3.5 cm. The wound was open with no drainage and 100% granulation tissue. The wound was originally noted on 6/23/14.</p> <p>Continued review of the non pressure wound assessment sheet dated 6/25/14 indicated another wound was noted to the right gluteal fold. The area was classified</p>				

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	<p>as incontinence associated dermatitis.</p> <p>The area measured 4 cm by 5 cm. The wound was open with no drainage and 100% granulation tissue. The wound was originally noted on 6/23/14.</p> <p>Further review of the non pressure wound assessment records indicated the last documented non pressure wound assessment was on 1/8/14 regarding an area on the resident's coccyx.</p> <p>Review of Nursing Notes dated 6/23/14 indicated there was no evidence an assessment of the right and left posterior gluteal folds was completed. There was no documentation measurements, color, odor, or drainage of the wounds to the resident's gluteal folds.</p> <p>Review of the current 9/11/12 Wound and Non Wound Assessment and Documentation policy provided by the Director of Nursing indicated "All wounds, as defined below, will be managed by the facility wound nurse. Each unit may have a particular wound nurse or there may be one wound nurse per facility. Assessment findings will be documented on the Pressure ulcer assessment and non pressure ulcer assessment, located in the EMR. Each</p>						

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	<p>week or more often if needed the wound assessment will be completed to include: location, stage, current status, measurement, description, pain associated, PUSH score and current treatment."</p> <p>Interview with LPN on 7/1/14 at 1:45 p.m. indicated the resident was complaining of pain to the back of her thighs. She further indicated she had assessed the back of her thighs on 6/23/14. The LPN indicated the resident's skin was red. like it had been burned. She further indicated the areas were open. The LPN indicated she did not document her assessment in the resident's chart or on a non pressure ulcer sheet when she had observed them on 6/23/14.</p> <p>Interview with the Wound Nurse on 7/1/14 at 2:00 p.m., indicated she sees the resident's open areas once weekly on Wednesdays. She indicated she had classified Resident #B's wounds as non pressure dermatitis related to incontinence. She indicated her first assessment of the right and left gluteal folds was on 6/25/14. She indicated they were both open and red. She indicated it</p>				

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	<p>was the facility's policy for Nursing staff to assess the areas and document the findings in the chart or on a non pressure assessment sheet. At that time, the Wound Nurse assessed the resident's wounds. She indicated the right gluteal fold looked a little worse than when she had first observed it and could see where the brief was cutting into the resident's thigh. She also indicated the dressings were too small and that she had given the staff the larger dressings to use.</p> <p>Interview with the Director of Nursing on 7/1/14 at 2:45 p.m. indicated the area to the right posterior thigh was first observed on 4/14/14 on a new skin condition sheet. She further indicated non pressure areas were to be monitored weekly until healed. She indicated there was no continuous assessment of the right posterior thigh after it was observed open.</p> <p>This Federal Tag relates to Complaint IN00151653 3.1-37(a)</p>				