

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/18/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN 47246
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00195395.</p> <p>This visit resulted in an Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00195395 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-223, 225, and 226.</p> <p>Survey dates: March 13, 14, 15, 16, and 17, 2016 Extended Survey Date: March 18, 2016</p> <p>Facility number: 000286 Provider number: 155579 AIM number: 100291000</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 12</p>	F 0000		
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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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F 0223 SS=G Bldg. 00	<p>Total: 66</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on March 27, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on observation, interview and record review, the facility failed to ensure psychosocial well-being of the resident was maintained related to inappropriate video/pictures of resident brief/toileting care, and pictures of residents without proper consent, by a staff member. This deficient practice affected 2 of 19 residents reviewed for abuse. (Resident #B and #C)</p> <p>Findings include:</p>	F 0223	F 223 Freefrom abuse/involuntary seclusion <b>What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice?</b> ·Resident #Bwas identified as having an unauthorized photo taken in a resident carearea. The MD and family were notified onMarch 14, 2016 at 5:30 pm. ·Staff #1counseled regarding policy on Abuse prohibition, reporting and investigation onMarch 15, 2016. ·Staff #2 who allegedly took theunauthorized photo is no	04/07/2016			

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	<p>1. During a confidential interview on 03/13/2016, Staff #1 indicated he/she had received a "Snap" ("Snapchat" name of video/picture program) of Resident #B's brief and stool.</p> <p>During a confidential interview on 03/13/2016, Staff #3 indicated Staff #2 was holding up his/her phone while Staff #3 was providing care to Resident #B. The staff member indicated he/she had not been aware that the care being provided was recorded at the time. Staff #3 reported to Staff #4 on 02/26/2016 that Staff #2 was video taping direct resident care.</p> <p>During a confidential interview on 03/13/2016, Staff #4 indicated on Friday, 02/26/2016, Staff #3 brought a concern to him/her about Staff #2 video taping during resident care. Staff #4 indicated they called the DON immediately and the DON was informed of the allegation, including the fact that a resident was filmed during care.</p> <p>During an interview on 03/13/2016 at 8:05 P.M., the Administrator indicated she had been informed of staff taking pictures of other staff in the facility on 02/26/2016, but was not aware staff had taken pictures and/or videos of residents except for a resident's hands.</p>		<p>longer employed by Millers Merry Manor.</p> <ul style="list-style-type: none"> <li>·Staff #3 is no longer employed byMillers Merry Manor.</li> <li>·Staff #4 and Staff #5 were re-educatedon Abuse prohibition, reporting and investigation on March 22, 2016.</li> <li>·Facility Administrator was suspendedMarch 14, 2016 through March 23, 2016 and upon return was re-educated on Abuseprohibition, reporting and investigation as well as attended the ISDH sponsoredleadership conference on Investigation on March 22, 2016.</li> <li>·Facility DON was suspended March 14,2016 and returned March 18, 2016 and upon return was re-educated on Abuseprohibition, reporting and investigation as well as attended the ISDH sponsoredleadership conference on Investigation on March 22, 2016.</li> <li>·ADON was re-educated on Abuseprohibition, reporting and investigation on March 14, 2016.</li> <li>·Resident #C was identified as havinga photo taken that he was unable to recall. The MD and family were notified on March 15, 2016.</li> <li>·Staff #26 and #27 were suspended andre-educated upon return on Abuse prohibition, reporting and investigation onMarch 17, 2016.</li> <li>·Staff #28 is no longer employedMillers Merry Manor.</li> </ul> <p><b>How will you identify other</b></p>				

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	<p>During a confidential interview on 03/14/2016, Staff #5 indicated he/she had heard rumors from several CNA's on 03/03/2016 that there was a video taken by staff of Resident #B being toileted.</p> <p>During a confidential interview on 03/14/2016, Staff #6 indicated he/she was present when a staff member had reported a video being taken of resident care to the DON and the Administrator the night the allegation occurred (02/26/2016).</p> <p>During an interview on 03/14/2016 at 1:20 P.M., the DON indicated, after being informed pictures were taken in the facility on 02/26/2016, she had not further confirmed if residents had been included in the pictures. The DON indicated the concern had been investigated as if no residents had been involved.</p> <p>During an interview on 03/14/2016 at 3:00 P.M., CNA #30 indicated he/she heard that staff were taking video/pictures of residents. CNA #30 further indicated he/she was shocked and would feel humiliated and angry if someone took her/his picture like the one taken of Resident #B.</p>		<p><b>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents residing in the facility have the potential to be affected by the alleged deficient practice.</li> <li>·All staff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Abuse prohibition, reporting and investigation policy (attachment A) which includes reporting of inappropriate video/pictures of residents being taken.</li> <li>·All staff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Social Networking policy and procedure (attachment B).</li> <li>·Social Service or designee will interview 10 residents weekly or interview families of those with a BIMS score of 12 or less weekly using interview questions from investigation (attachment C). BIMS scores 8-12: moderately impaired and 0-7: severe impairment</li> <li>·DON or designee will interview 10 staff members' weekly x8 then, monthly x3, and then on going as needed using interview questions from investigation(attachment D).</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·All staff will be re-inserviced by</li> </ul>	

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	<p>During an interview on 03/14/2016 at 3:30 P.M., CNA #33 indicated he/she would have been sad and upset if pictures/video had been taken his/her family members like that had been of Resident #B. He/She further indicated no one knows who could end up seeing the pictures.</p> <p>During an interview on 03/14/2016 at 3:33 P.M., the ADON indicated when the allegation of a video being taken during resident care had been brought to her, she had assumed the video had just been of the staff member and did not include a resident.</p> <p>Resident #B's clinical record was reviewed on 03/13/16 at 5:00 P.M. Diagnoses included, but were not limited to, cerebrovascular disease and dementia.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 02/05/16, indicated Resident #B was cognitively impaired, with a BIMS (Brief Interview for Mental Status) score of 04 out of a possible 15. Resident #B, required extensive assistance of two staff members for toilet use and total dependence for personal hygiene. Resident #B was noted to be frequently incontinent of bladder and occasionally incontinent of bowel.2. Paperwork for the investigation</p>		<p>the Assistant Director of Nursing or designee on or before April 7, 2016 on Abuse Prohibition, Reporting, and Investigation which includes reporting of inappropriate video/pictures of residents without proper consent.</p> <ul style="list-style-type: none"> <li>· QAtool titled "Resident Rights" (attachment E) will be used daily x30, weekly x4, and then monthly x6 and ongoing as needed.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· QAtool titled Resident Rights (attachment E) will be completed daily x30 days for a sample of 10 then weekly x4 then monthly x6 and ongoing as needed.</li> <li>· For those residents who are cognitively impaired Social Service Director or designee will interview 10 residents' or families of those with a BIMS score of 12 or less weekly using interview questions from investigation (attachment C) weekly x8 then monthly x3 and ongoing as needed.</li> <li>· The facility is requesting a face to face IDR of tag F-tag 223 with a scope and severity of G. Through the IDR process the facility is seeking to have this tag deleted or in its alternative reduced. The facility will provide documentation to show evidence that the facility took all measures to ensure psychosocial well-being</li> </ul>	

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	<p>conducted by the facility, including interviews and incident reports, was provided by the Regional Vice President on 03/17/2016 at 9:07 A.M. and was reviewed at that time. The investigation summary indicated CNA #26, CNA #27, and CNA #28 had their picture taken with "a resident they were fond of." (Resident #C)</p> <p>The allegations of video/pictures were indicated to occur a few weeks prior to 03/15/2016 and on 02/26/2016 were reported by the facility to the Indiana State Department of Health on 03/15/2016.</p> <p>During an interview conducted by the facility on 03/15/2016 at 11:15 A.M., CNA #26 indicated there was a photo taken with herself, CNA #27, CNA #28 and Resident #C "at least a month ago." The CNA further indicated Resident #C's family had not given her permission to take the photo.</p> <p>During an interview conducted by the facility on 03/15/2016 at 1:55 P.M., CNA #27 indicated CNA #26, CNA #28 and herself took a photo with Resident #C in the resident's room while Resident #C was fully clothed and awake.</p> <p>During an interview on 03/17/2016, the</p>		of Resident #B and #C was maintained. In addition the facility will prove that there was no actual harm of Resident#B or #C.				

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	<p>QA (Quality Assurance) Nurse #25 indicated two CNA's (CNA #26 and CNA #27) admitted to taking a picture with Resident #C. The QA Nurse indicated both CNA's reported Resident #C agreed to having the picture taken and the resident was sitting up in bed, fully clothed during the picture. QA Nurse #25 indicated Resident #C did not remember the incident involving having his picture taken.</p> <p>During an interview on 03/17/2016 at 10:40 A.M., the Regional Vice President indicated Resident #C was involved in a group "selfie" with a few of the staff. He further indicated taking a picture with Resident #C was considered unacceptable because the resident was mentally incapable of giving proper consent and did not remember the picture with staff occurring.</p> <p>Resident #C's most recent admission MDS (Minimum Data Set) assessment, dated 02/11/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 13 and was cognitively intact. Resident #C's diagnoses included, but were not limited to, aphasia, dementia, and depression.</p> <p>The current facility policy, titled "Abuse Prohibition, Reporting, and</p>			

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	<p>Investigation" and dated 07/15/2015, was provided by the Administrator on 03/14/2016 at 9:01 A.M. and was reviewed at that time. The policy indicated the definition of sexual abuse included "photographing a resident's Rectal [sic], genital or breast areas" and the definition of mental abuse included "humiliation". The policy further indicated mistreatment of a resident involved staff treating a resident inappropriately or exploiting a resident, including "taking unauthorized photos or recordings of residents."</p> <p>The current facility policy, titled "Social Networking" and dated 02/12/2010, was provided by the Quality Assurance Corporate Nurse on 03/14/2016 at 4:49 P.M. and was reviewed at that time. The policy indicated, "...All posts should be respectful to...residents...Avoiding defamatory statements such as those containing images, photographs...that are offensive or sexually explicit...Social media activities are not authorized during working times or in working areas..."</p> <p>This Federal tag relates to complaint IN00195395.</p> <p>3.1-27(a)(1)</p>			

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F 0225 SS=J Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review,</p>	F 0225	F225 Investigate/Report	04/07/2016	

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	<p>the facility failed to adequately investigate an allegation of abuse and ensure the immediate reporting of an allegation of abuse to the Indiana State Department of Health, when a staff member used a phone to take a video/picture of resident care (Resident #B) and shared it with other employees via social media, for 1 of 11 residents reviewed for abuse.</p> <p>The Immediate Jeopardy began on the evening of 02/26/2016, when a staff member videotaped/took a picture of Resident #B's personal care and shared the video/picture on social media. The Administrator and the Quality Assurance Corporate Nurse were notified of the Immediate Jeopardy at 2:15 P.M., on 03/14/2016. The Immediate Jeopardy was removed on 3/16/2016, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>During a confidential interview on 03/13/2016, Staff #1 indicated he/she had received a "Snap" ("Snapchat" name of video program) of Resident #B's brief and stool. The staff member indicated,</p>		<p><b>Allegations/Individuals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #B was identified as having an unauthorized photo taken in a resident care area. The MD and family were notified on March 14, 2016 at 5:30 pm.</li> <li>·Staff #1 counseled regarding policy on Abuse prohibition, reporting and investigation on March 15, 2016.</li> <li>·Staff #2 who allegedly took the unauthorized photo is no longer employed by Millers Merry Manor.</li> <li>·Staff #3 is no longer employed by Millers Merry Manor.</li> <li>·Staff #4 and Staff #5 were re-educated on Abuse prohibition, reporting and investigation on March 22, 2016.</li> <li>·Facility Administrator was suspended March 14, 2016 through March 23, 2016 and upon return was re-educated on Abuse prohibition, reporting and investigation as well as attended the ISDH sponsored leadership conference on Investigation on March 22, 2016.</li> <li>·Facility DON was suspended March 14, 2016 and returned March 18, 2016 and upon return was re-educated on Abuse prohibition, reporting and investigation as well as attended the ISDH sponsored leadership conference on Investigation on</li> </ul>		

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	<p>after receiving the "Snap", he/she did not inform management, but instead told Staff #3 there was a video of him/her providing resident care and was told by Staff #3 he/she would go to the Administrator. Staff #1 indicated Staff #2 had sent the video and that he/she was able to identify the resident by the amount and type of stool in the video and the staff member by the voice in the video.</p> <p>During a confidential interview on 03/13/2016, Staff #3 indicated Staff #2 was holding up his/her phone while Staff #3 was providing resident care to Resident #B. The staff member indicated he/she had not been aware the care being provided was being recorded at the time. Staff #3 reported to Staff #4 on 02/26/2016 that Staff #2 was video taping direct resident care. Staff #4 assured Staff #3 that it would be reported to the DON and Administrator. Staff #3 was aware Staff #4 called the DON right away. Staff #3 indicated the Administrator called the facility and spoke with Staff #2 and informed the staff to delete any pictures off their phones. Staff #3 indicated the next day (02/27/2016) when they came in to work, they again reported the allegation of a video/and or pictures being taken of resident care again to the Administrator.</p>		<p>March 22, 2016.</p> <ul style="list-style-type: none"> <li>·ADON was re-educated on Abuseprohibition, reporting and investigation on March 14, 2016</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what correctiveaction will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents residing in the facility have the potential to be affected by the alleged deficient practice.</li> <li>·All staff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Abuse prohibition, reporting and investigation policy and procedure (Attachment A) which includes reporting of inappropriate video/pictures of residents without proper consent.</li> <li>·Socialservice or designee will interview 10 residents weekly or interview families ofthose with a BIMS score of 12 or less weekly x8 then, monthly x3, and then ongoing as needed using interview questions from investigation (attachment C). BIMS scores 8-12: moderately impaired and 0-7: severe impairment</li> <li>·DONor designee will interview 10 staff members weekly x8 then, monthly x3, andthen on going as needed using interview questions from investigation(Attachment D).</li> </ul> <p><b>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient</b></p>				

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	<p>During a confidential interview on 03/13/2016, Staff #4 indicated on Friday, 02/26/2016, Staff #3 brought a concern to him/her about Staff #2 video taping during resident care. Staff #4 indicated they called the DON immediately and informed them of the allegation, including the fact that it was a resident being filmed during care. Staff #4 indicated the Administrator called the facility that night (02/26/2016) and told the staff they were not to be taking pictures and to delete any pictures they had on their phones. Staff #4 indicated when they returned to the facility on Monday (02/29/2016), they were concerned about the situation and took the concern directly to the Administrator. The Administrator claimed to not know that the pictures had involved resident care, Staff #4 informed her of the allegations made by Staff #3 that pictures and/or video had been taken during direct resident care of Resident #B.</p> <p>During a confidential interview on 03/14/2016, Staff #5 indicated he/she had heard rumors from several CNA's on 03/03/2016 that there was a video taken by staff of Resident #B being toileted. Staff #5 indicated he/she informed the ADON (Assistant Director of Nursing) of the concern on 03/03/2016 and was told</p>		<p><b>practice does notrecur?</b></p> <ul style="list-style-type: none"> <li>·Allstaff will be re-inserviced by the Assistant Director of Nursing or designee on or before April 7, 2016 on Abuse Prohibition, Reporting, and Investigation policy and procedure (Attachment A) which includes which includes reporting of inappropriate video/pictures of residents without consent and immediate reporting to the facility Administrator.</li> <li>·QA tool titled "Resident Rights" (Attachment E) will be used daily x30, weekly x4, then monthly x6 and ongoing as needed.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·QA tool titled Resident Rights (Attachment E) will be completed daily x30 days for a sample of 10 then weekly x4 then monthly x6 and ongoing as needed.</li> <li>·For those residents who are cognitively impaired Social Service Director or designee will interview 10 residents' or families of those with a BIMS score of 12 or less weekly using interview questions from investigation (Attachment C) weekly x8 then monthly x3 and ongoing as needed.</li> </ul> <p>The facility is requesting a face to face IDR of tag F-tag225 with a scope and severity of J. Through the IDR process the facility is seeking to have</p>		

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	<p>by the ADON that she would address the issue.</p> <p>During a confidential interview on 03/14/2016, Staff #6 indicated he/she was aware a staff member had reported a video being taken of resident care to the DON and the Administrator the night the allegation occurred (02/26/2016). Staff #6 indicated the Administrator had called the facility the night of the allegation, 02/26/2016, and had told staff all pictures needed to be deleted off their phones.</p> <p>During a confidential interview on 03/14/2016, Staff #7 indicated he/she was told on 02/27/2016 by another staff member that a video had been taken of a resident during resident care. Staff #7 indicated he/she notified the Administrator the next morning (02/28/2016), as it was very late.</p> <p>During an interview on 03/13/2016 at 8:05 P.M., the Administrator indicated Staff #3 had reported Staff #2 taking pictures of them (Staff #3) despite being asked to stop on 02/26/2016. The Administrator indicated when she was informed, she had called the facility on 02/26/2016 immediately and spoken to Staff #2 and told him/her they were not to be taking pictures or using their phone in the facility. The Administrator further</p>		<p>this tag deleted or in its alternative reduced. The facility will provide documentation to show evidence that the facility investigated an allegation of abuse and reported upon awareness of allegation for Resident #B. In addition the facility will prove that there was no immediate jeopardy to Resident #B.</p>		

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	<p>indicated she and the AIT (Administrator in Training) talked to Staff #2 the following Monday, 02/29/2016, and asked the staff member if she had taken any pictures of residents, to which he/she replied, "no." The Administrator indicated Staff #2 had assured her that no pictures of residents had been taken, only pictures of staff. She indicated the staff had been inserviced about HIPAA (Health Insurance Portability and Accountability Act), privacy, and abuse on 02/29/2016, 03/01/2016, and 03/07/2016. The Administrator indicated she had never been told by any staff there was a video and/or picture of a resident or resident care. The Administrator further indicated the procedure for an allegation of abuse, such as pictures of residents being taken, included reporting the allegation and investigating by interviewing staff and residents.</p> <p>During an interview on 03/14/2016 at 1:20 P.M., the DON indicated a staff member had called her on Friday (02/26/2016) night and told her pictures were being taken in the facility. She indicated she was told by staff that the pictures were being taken of Staff #3 when he/she did not want to be photographed and there was a possibility of a picture being taken in the shower room, but the staff member was not sure.</p>			

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	<p>The DON indicated she did not ask further to confirm if any residents were in the pictures. The DON indicated she informed the Administrator via text message on 02/26/2016 and when she called to make sure the information had been received, the Administrator told her it had already been handled. The DON indicated the concern was not investigated as if residents were involved. She indicated the Administrator had handled the situation by calling the facility and informing staff that pictures were not to be taken in the facility, talking to second shift about not taking pictures, and telling second shift to inform the other shifts about not taking pictures.</p> <p>During an interview on 03/14/2016 at 3:33 P.M., the ADON indicated Staff #3 had brought the concern to her and to the Administrator at a different time that a video had been taken during resident care, but that she assumed it was just of the staff member and did not include the resident. The ADON indicated she did not ask if the video included the resident. The ADON further indicated residents were not interviewed regarding the allegations until this week (03/13/2016).</p> <p>The Concern Record, dated 02/26/2016, indicated an aide (Staff #3) said a</p>						

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	<p>coworker (Staff #2) was taking their picture and sending it to others. The Administrator immediately called the building and spoke with Staff #2 and reminded the staff that no cellphones were to be used in the building and photos could not be taken in the building at any time. The plan of action, starting 02/26/2016, included the Administrator and the AIT speaking with Staff #2 on 02/29/2016 regarding taking pictures of staff and/or residents, reviewing the policy regarding cellphones and pictures with Staff #2, and inservicing nursing staff on the cell phone/picture policy and procedure. There was no plan included to interview residents or other staff, or to suspend the accused staff member.</p> <p>The "Abuse Prohibition, Reporting, and Investigation" policy indicated, "All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative...as soon as feasibly possible, but no later than within 24 hours of the reporting or discovery of the incident..." and "...Violations...will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law..."</p> <p>The Immediate Jeopardy began on</p>						

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F 0226 SS=J Bldg. 00	<p>02/26/2016, was removed on 3/16/2016 when the facility completed interviews with resident and staff, educated staff regarding the abuse and immediate reporting of abuse. The Immediate Jeopardy was removed on 3/16/2016, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on abuse and immediate reporting of abuse.</p> <p>This Federal tag relates to complaint IN00195395.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure policy and procedures were followed in reporting an allegation of abuse by an employee towards a resident to the Indiana State</p>	F 0226	<b>F 226 Develop/Implement Abuse/Neglect, etc Policies What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b>	04/07/2016			

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	<p>Department of Health when a staff member video taped/took a picture of a resident without their consent for 1 of 11 residents reviewed for abuse in a sample of 11. (Resident #B)</p> <p>The Immediate Jeopardy began on the evening of 02/26/2016, when a staff member videotaped/took a picture of Resident #B's personal care and shared the video/picture on social media. The Administrator and the Quality Assurance Corporate Nurse were notified of the Immediate Jeopardy at 2:15 P.M., on 03/14/2016. The Immediate Jeopardy was removed on 3/16/2016, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>Starting on 02/26/2016, allegations of videos and/or photographs being taken during resident care were reported by staff to the Administrator, the DON, and the ADON. The investigation of these allegations only included interviewing the one identified staff member (Staff #2), who was not suspended at that time. In services were held for nursing staff following the incident. The allegations</p>		<p><b>practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #B was identified as having an unauthorized photo taken in a resident care area. The MD and family were notified on March 14, 2016 at 5:30 pm.</li> <li>·Staff #1 counseled regarding policy on Abuse prohibition, reporting and investigation on March 15, 2016.</li> <li>·Staff #2 who allegedly took the unauthorized photo is no longer employed by Millers Merry Manor.</li> <li>·Staff #3 is no longer employed by Millers Merry Manor.</li> <li>·Staff #4, Staff #5, and Staff #7 were re-educated on Abuse prohibition, reporting and investigation on March 22, 2016.</li> <li>·Facility Administrator was suspended March 14, 2016 through March 23, 2016 and upon return was re-educated on Abuse prohibition, reporting and investigation as well as attended the ISDH sponsored leadership conference on Investigation on March 22, 2016.</li> <li>·Facility DON was suspended March 14, 2016 and returned March 18, 2016 and upon return was re-educated on Abuse prohibition, reporting and investigation as well as attended the ISDH sponsored leadership conference on Investigation on March 22, 2016.</li> <li>·ADON was re-educated on Abuse prohibition, reporting and investigation on March 14, 2016.</li> </ul> <p><b>How will you identify other</b></p>		

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	<p>were not reported to the Indiana State Department of Health. The timeline, as reported by staff and administration, was as follows:</p> <p>On 02/26/2016, Staff #2 recorded Staff #3 providing personal care to Resident #B and shared it on social media with other employees, including Staff #1.</p> <p>After receiving the video/picture, Staff #1 reported to Staff #3 that he/she was videoed/photographed providing resident care. Staff #3 then brought the concern to Staff #4 that evening on 02/26/2016.</p> <p>Staff #4 immediately call the DON (Director of Nursing) on 02/26/2016 and the DON texted the Administrator the same night (02/26/2016). Following this text, the Administrator called the facility and informed Staff #2 he/she could not take pictures and/or videos and needed to delete any pictures/videos he/she had taken and that all staff needed to delete any pictures/videos that had been taken. The DON followed up with the Administrator on 02/26/2016 and was informed the concern had been handled.</p> <p>On 02/27/2016, Staff #3 brought the concern of being filmed/photographed during resident care to the Administrator. Also on 02/27/2016, Staff #7 was</p>		<p><b>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents residing in the facility have the potential to be affected by the alleged deficient practice.</li> <li>·All staff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Abuse prohibition, reporting and investigation policy and procedure (Attachment A). Including reporting of inappropriate video/pictures of residents without consent and that any allegations of abuse be immediately reported to the facility Administrator.</li> <li>·All staff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Social Networking policy and procedure (Attachment B).</li> <li>·Social service or designee will interview 10 residents' or families of those with a BIMS score of 12 or less weekly x8 then, monthly x3, and then on going as needed using interview questions from investigation (Attachment C).</li> <li>·DON or designee will interview 10 staff members weekly x8 then, monthly x3, and then on going as needed using interview questions from investigation (Attachment D).</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p>		

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	<p>notified of a video and/or picture being taken during resident care and brought the concern to the Administrator the next morning on 02/28/2016.</p> <p>The Administrator and the AIT (Administrator in Training) spoke with Staff #2 on 02/29/2016 and questioned the staff member regarding taking pictures in the facility of staff and/or residents.</p> <p>On 02/29/2016, Staff #4 again informed the Administrator of the allegations of a video/picture being taken during personal care for Resident #B.</p> <p>Staff were inserviced regarding HIPAA (Health Insurance Portability and Accountability Act), privacy, and cellphones on 02/29/2016, 03/01/2016, and 03/07/2016.</p> <p>On 03/03/2016, Staff #5 heard concerns of a video/picture being taken of Resident #B being toileted and brought the concern to the ADON (Assistant Director of Nursing).</p> <p>During an interview on 03/13/2016 at 8:05 P.M., the Administrator indicated she had been informed of staff taking pictures of other staff in the facility on 02/26/2016, but was not aware staff had</p>		<p>·Allstaff will be re-inserviced by the Assistant Director of Nursing or designee on or before April 7, 2016 on Abuse Prohibition, Reporting, and Investigation policy and procedure (Attachment A) which includes reporting of inappropriate video/pictures of residents without proper consent.</p> <p>·Allstaff will be re-inserviced on the alleged deficient practice on or before April 7, 2016 regarding Social Networking policy and procedure (Attachment B).</p> <p>·QA tool titled "Resident Rights" (Attachment E) will be used daily x30, weekly x4, and then monthly x6 and ongoing as needed.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·QA tool titled Resident Rights (Attachment E) will be completed daily x30 days for a sample of 10 then weekly x4 then monthly x6 and ongoing as needed.</p> <p>·For those residents who are cognitively impaired Social service Director or designee will interview 10 residents' or families of those with a BIMS score of 12 or less weekly using interview questions from investigation (Attachment C) weekly x8 then monthly x3 and ongoing as needed.</p> <p><i>The facility is requesting a face to face IDR of tag F-tag 226 with a scope and severity of J. Through</i></p>		

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	<p>taken pictures and/or videos of residents except for a resident's hands. The Administrator indicated she had interviewed Staff #2 on 02/29/2016 regarding taking pictures in the facility and had inservices done for nursing staff regarding HIPAA (Health Insurance Portability and Accountability Act), privacy, and abuse on 02/29/2016, 03/01/2016, and 03/07/2016.</p> <p>During an interview on 03/14/2016 at 1:20 P.M., the DON indicated, after being informed pictures were being taken in the facility on 02/26/2016, she had not asked further to confirm if any residents had been included in the pictures. The DON indicated the concern had been investigated as if no residents had been involved.</p> <p>During an interview on 03/14/2016 at 3:33 P.M., the ADON indicated when the allegation of a video being taken during resident care had been brought to her, she had assumed the video had just been of the staff member and did not include a resident. The ADON further indicated residents had not been interviewed regarding the allegations until this week (03/13/2016).</p> <p>The current facility policy, titled "Abuse Prohibition, Reporting, and</p>		<p><i>the IDR process the facility is seeking to have this tag deleted or in its alternative reduced. The facility will provide documentation to show evidence that the facility did follow the reporting of an allegation of abuse upon knowledge of allegation for Resident #B. In addition the facility will prove that there was no immediate jeopardy to Resident #B</i></p>		

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	<p>Investigation" and dated 07/15/2015, was provided by the Administrator on 03/14/2016 at 9:01 A.M. and was reviewed at that time. The policy indicated, "...Miller's Health Systems has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse...are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures..." and "...has policies and procedures in place that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process..." The policy indicated the definition of sexual abuse included "photographing a resident's Rectal [sic], genital or breast areas" and the definition of mental abuse included "humiliation". The policy further indicated mistreatment of a resident involved staff treating a resident inappropriately or exploiting a resident, including "taking unauthorized photos or recordings of residents."</p> <p>The "Abuse Prohibition, Reporting, and Investigation" policy indicated, "All reports of alleged abuse/abuse and all unusual occurrences, must be reported to the Administrator immediately, and to the resident's representative...as soon as feasibly possible, but no later than within</p>			

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	<p>24 hours of the reporting or discovery of the incident..." and "...Violations...will be reported to the Long Term Care Division of the Indiana State Department of Health and other officials in accordance with state law..."</p> <p>The current "Investigation and Reporting to Correct Authority" policy dated 07/15/2015, was provided by the administrator on 03/14/2016 at 9:01 A.M. and reviewed at that time. The policy indicated, "...The Administrator, or designee, shall initiate and direct the investigation immediately, and within 5 days a report of this investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health...Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed. A thorough investigation will be initiated and employee conduct policies implemented as appropriate...Residents will be questioned (if alert and competent) about the nature of the incident, and their statements will be put in writing...An investigation will be completed to assure other residents have not been affected...This may involve interviewing staff members when appropriate..."</p>			

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	<p>The current facility policy, titled "Social Networking" and dated 02/12/2010, was provided by the Quality Assurance Corporate Nurse on 03/14/2016 at 4:49 P.M. and was reviewed at that time. The policy indicated, "...All posts should be respectful to...residents...Avoiding defamatory statements such as those containing images, photographs...that are offensive or sexually explicit...Social media activities are not authorized during working times or in working areas...</p> <p>The Immediate Jeopardy began on 02/26/2016, was removed on 03/16/2016 when the facility completed interviews with resident and staff, educated staff regarding the abuse and immediate reporting of abuse. The Immediate Jeopardy was removed on 3/16/2016, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on abuse and immediate reporting of abuse.</p> <p>This Federal tag relates to complaint IN00195395.</p> <p>3.1-28(a)</p>			

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure</p>	F 0441	F441 Infection Control, Prevent Spread, Linens	04/07/2016	

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	<p>proper infection control procedures were followed related to cleaning resident care equipment, washing hands appropriately, maintaining proper contact isolation precautions, and handling dirty linens for 5 of 20 residents observed for infection control practices. (Resident #12, #20, #44, #59, and #64)</p> <p>Findings include:</p> <p>1. During an observation on 03/14/2016 at 9:56 A.M., RN (Registered Nurse) #18 and CNA (Certified Nurse Aide) #19 assisted Resident #64 to the 100 Hall Assisted Bathing Room. RN #18 and CNA #19 assisted the Resident #64 onto the raised toilet seat and moved the seat over the toilet.</p> <p>After the Resident was finished using the toilet, CNA #19 took Resident #64 out of the room while RN #18 donned gloves, flushed the toilet, washed her hands, and picked up the bottle of perineal cleanser that had been used. The raised toilet seat that had been used by the resident was left over the toilet and was not cleaned.</p> <p>The 100 Hall Assisted Bathing Room was observed from 03/14/2016 at 10:12 A.M. until 10:35 A.M. CNA #20 opened the bathing room door, but did not fully enter the room. No other staff entered to</p>		<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #12 was identified to have used the toilet riser prior to cleaning of the equipment after prior use with no ill effect.</li> <li>·Staff #18, #19, and #20 have been re-educated on proper disinfecting of equipment in between uses of residents on or before April 7, 2016.</li> <li>·Staff #11, #24, and Staff #19 will be re-educated on or before April 7, 2016 on Handwashing policy and procedure.</li> <li>·Staff #21 and #23 will be re-educated on or before April 7, 2016 on Linen Handling policy and procedure.</li> <li>·No residents have been affected by this deficient practice of linen handling.</li> <li>·Resident #20 was identified as receiving a breathing treatment without proper PPE being worn by staff #22 and #24.</li> <li>·Staff #24 will be re-educated on or before April 7, 2016 on Isolations procedures.</li> <li>·Staff #22 was informed on March 18th, 2016 the reason for isolation for Resident #20.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>				

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	<p>clean the used raised toilet seat.</p> <p>During an observation on 03/14/2016 at 10:35 A.M. CNA #19 and CNA #20 took Resident #12 into the 100 Hall Assisted Bathing Room. After washing hands appropriately and donning gloves, the CNA's assisted Resident #12 to stand using the grab bar. CNA #20 turned and positioned Resident #12 to sit down on the raised toilet seat, which was previously used by Resident #64 and not cleaned.</p> <p>During an interview on 03/14/2016 at 10:37 A.M., CNA #20 indicated the raised toilet seats in the assisted bathing room were supposed to be cleaned after each resident's toileting use.</p> <p>During an interview on 03/14/2016 at 10:44 A.M., CNA #19 indicated the raised toilet seats were supposed to be cleaned after every use. The CNA further indicated she forgot to clean the seat after it was used by Resident #64.</p> <p>During an interview on 03/18/2016 at 8:29 A.M., the ADON (Assistant Director of Nursing) indicated raised toilet seats should be sanitized after each use with the cleansing spray.</p> <p>2. During an observation on 03/16/2016</p>		<p><b>correctiveaction will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents residing in the facility have the potential to be affected by the alleged deficient practice.</li> <li>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee of cleaning and disinfecting resident care equipment in-between uses (Attachment F).</li> <li>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Handwashing policy and procedure. (Attachment G)</li> <li>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Linen Handling policy and procedure. (Attachment H)</li> <li>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Contact transmission-based precautions. (Attachment I)</li> <li>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Clostridium Difficile policy and procedure. (Attachment J)</li> </ul> <p><b>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?</b></p>				

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	<p>at 9:14 A.M., Staff #11 washed her hands for six seconds, scrubbing lightly at her palms while holding her hands under water. After washing her hands, Staff #11 wet a paper towel in the sink with her bare hands, and handed the paper towel to RN #24. RN #24 used the wet paper towel to wipe off Resident #44's hands.</p> <p>During an interview on 03/18/2016 at 3:56 P.M., the DON (Director of Nursing) indicated hands should be scrubbed for 20 seconds.</p> <p>The current facility policy, titled "Hand Washing and Hand Asepsis" and dated 07/27/2012, was provided by the ADON on 03/13/2016 at 6:16 P.M. and was reviewed at that time. The policy indicated, "...Rub vigorously for at least 20 seconds. (Lace your fingers together to wash in between them.) ...Clean nails by rubbing them in palm of other hand ..."</p> <p>3. During an observation on 03/16/2016 at 9:22 A.M., Housekeeper #21 carried a stack of used clothing protectors against his chest and set them on top of a table. The Housekeeper then picked up more clothing protectors, holding them against his body as he went to each table. Housekeeper #23 was holding a stack of used clothing protectors against her body and put the linens in the linen hamper.</p>		<p>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee of cleaning and disinfecting resident care equipment in in-between uses (Attachment F).</p> <p>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Handwashing policy and procedure. (Attachment G)</p> <p>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Linen Handling policy and procedure. (Attachment H)</p> <p>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Contact transmission-based precautions. (Attachment I)</p> <p>·All staff will be re-inserviced on or before April 7, 2016 by Assistant Director of Nursing or designee on Clostridium Difficile policy and procedure. (Attachment J)</p> <p>·Director of Nursing and/or designee will complete the QA tool titled "Infection Control Review" daily x30, weekly x4, monthly x3 and quarterly thereafter. (Attachment K)</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</b></p>		

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	<p>Housekeeper #21 filled a large, clear trash bag with the used clothing protectors and, dragging the bag the entire length of the hallway, took the bag to the laundry room.</p> <p>During an observation on 03/16/2016 at 9:41 A.M., Housekeeper #21 gathered used table cloths from the tables, holding the table cloths against his body before putting the linens in a trash bag. After all the linens were gathered, Housekeeper #21 carried the bag of linens slung over his shoulder, against his uniform, to the laundry room.</p> <p>During an interview on 03/18/2016 at 8:29 A.M., the ADON indicated soiled linen should not be held against the body and should be bagged. She further indicated the bag should be carried, not dragged along the floor or up against the body.</p> <p>The current facility policy, titled "Linen Handling" and dated 06/09/2010, was provided by the AIT (Administrator in Training) on 03/18/2016 at 11:23 A.M. and was reviewed at that time. The policy indicated, "...Linens and laundry are handled or transported in a manner to prevent the spread of infection and/or contamination ...Linen should not be held against the staff member's uniform during</p>		<p><b>assurance program will be put into place?</b></p> <p>·Director of Nursing and/or designee will complete the QA tool titled "Infection Control Review" daily x30, weekly x4, monthly x3 and quarterly thereafter. (Attachment K)</p>				

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	<p>transport or delivery ..."</p> <p>4. During an observation on 03/16/2016 at 10:37 A.M., CNA #19 entered Resident #59's room, donned gloves, pulled trash bags from the resident's trash can, put the resident's breakfast tray into the bag, removed her gloves, used hand sanitizer, and carried the bagged tray out of the room. CNA #19 did not wash her hands prior to leaving the room.</p> <p>During an interview on 03/16/2016 at 10:54 A.M., RN #24 indicated Resident #59 was in isolation for Clostridium Difficile.</p> <p>During an observation on 03/18/2016 at 8:13 A.M., RN #24 prepared and administered a breathing treatment for Resident #20. After starting the resident's treatment, and without washing or sanitizing her hands, the RN opened her cart, put away supplies after cleaning them, and charted in the MAR (Medication Administration Record) RN #24 was not wearing a gown or gloves while in Resident #20's room.</p> <p>During an observation and interview on 03/18/2016 at 8:35 A.M., Housekeeper #22 entered Resident #20's room, opened one of the resident's drawers, and exited the room. Housekeeper #22 did not wash</p>				

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	<p>or sanitizer her hands after exiting the room. Housekeeper #22 indicated she did not know why Resident #20 was in isolation.</p> <p>During an interview on 03/17/2016 at 2:41 P.M., RN #18 indicated ) Resident #20 was on contact isolation for ESBL (Extended Spectrum Beta-Lactamase in the urine.</p> <p>During an interview on 03/18/2016 at 8:29 A.M., the ADON indicated when a resident had ESBL, contact isolation precautions were followed. The ADON indicated this included wearing gloves while in the resident's room and a gown if there was a possibility of being splattered. She further indicated hand sanitizer should be used prior to leaving the resident's room. The ADON indicated when a resident had Clostridium Difficile, contact precautions were followed, which included wearing gloves when in the resident's room and a gown if there was a possibility of splatter. She further indicated hands must be washed using soap and water when exiting a Clostridium Difficile isolation room.</p> <p>The current facility policy, titled "Clostridium Difficile", was provided by the DON on 03/18/2016 at and was reviewed at that time. The policy</p>			

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F 9999  Bldg. 00	<p>indicated, "...Perform hand hygiene using soap and water...(Alcohol-based hand rubs may not be effective against spore-forming bacteria)..."</p> <p>The current "Contact Precautions" procedure was provided by the AIT on 03/18/2016 at 5:09 P.M. and was reviewed at that time. The procedure indicated, "...Apply gloves and gown before entering room...Perform all care for residents while wearing gloves and gown...After care is complete, remove gloves and gown, wash hands with soap and water and exit room without touching resident or any surface..."</p> <p>3.1-18(j) 3.1-18(l) 3.1-19(g)(1)</p> <p>3.1-14(a) PERSONNEL</p> <p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p>	F 9999	<p>F9999</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>·Staff #13 is no longer employed by Millers Merry Manor effective March 17, 2016.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>	04/07/2016			

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	<p>Based on record review and interview the facility failed to review a criminal background check and act on the resulting information for a new employee for 1 of 10 employee records reviewed. (CNA, Certified Nurse Aide, #13)</p> <p>Findings include:</p> <p>The criminal background check for CNA #13 was provided by the QA (Quality Assurance) Nurse #25 on 03/17/2016 at 1:15 P.M., and reviewed at that time. The background check, with a requested date of 01/08/2016, indicated CNA #13 was found guilty of conversion (theft) with an arrest date of 08/16/2012.</p> <p>Employee time sheets were provided by the QA Nurse #25 on 03/17/2016 at 1:15 P.M., and reviewed at that time. The records indicated CNA #13 had worked 46 days out of 63 from 01/11/2016 thru 03/14/2016.</p> <p>During an interview on 03/17/2016 at 2:06 P.M., the RVP (Regional Vice President) indicated the payroll clerk in the front office processed the criminal background check reports on prospective employees, gave the reports to the head of the department applied for, who then would follow up with the administrator. He further indicated if anything surfaced</p>		<p><b>correctiveaction will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to beaffected by this deficient practice.</li> <li>·All employee files were audited toensure criminal background checks were reviewed and ensuring there were noconvictions or pending convictions upon hire.</li> </ul> <p><b>What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·All staffresponsible for hiring of staff was trained on April 4, 2016 by Corporate HumanResources Department Manager on the hiring process which included thebackground check review.</li> <li>·Administratorwill review all criminal back ground checks to ensure appropriateemployment.</li> </ul> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Office Manageror designee will utilize the QA tool that is titled "Employee Records" (Attachment L)to monitor for compliance withpre-employment screening for criminal background checks as an ongoing auditprocess.</li> </ul>				

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	<p>on the report, the facility may call the corporate office to double check the background report to see if there was a conflict with the company policy. The RVP indicated the background report was not reviewed and was ultimately the responsibility of the administrator.</p> <p>During an interview on 03/18/2016 at 4:58 P.M., the ADON indicated she and the DON, together, interviewed and hired the CNAs. She further indicated she filled out the, "Department Head New Hire Checklist," and the form was filled out prior to the hire date, which was listed as 01/11/2016. The ADON indicated in regards to CNA #13's background check, she was not aware of any problems until this week.</p> <p>The current Personnel Policy and Procedure for Criminal History Checks, dated 07/15/2015, was provided by the QA Nurse #25 on 03/17/2016 at 1:15 P.M., and reviewed at that time. The policy indicated, "...If the Limited Criminal History Information reveals that the prospective employee has been convicted of...Theft, if the conviction for theft occurred less than five (5) years before the person's employment application date..."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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