STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 14, 15, 16, 17, & 20 2012 Facility number: 000342 Provider number: 155573 AIM number: 100289140 Survey team: Angel Tomlinson, RN TC Leslie Parrett, RN Sharon Lasher, RN Barbara Gray, RN Census bed type: SNF: 4 SNF/NF: 33 Total: 37 Census payor type: Medicare: 6 Medicaid: 28 Other: 3 Total: 37 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on August 22, 2012 by Bev Faulkner, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to notify the family or physician of 1 resident's continued, loose watery diarrhea for 1 of 11 residents reviewed for	F0157	Plan of Correction for Middletown 2567 8-13-2012 We respectfully request paper compliance for this plan of correction. All of the attachments to indicate we are meeting the requirements of	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notification. (Resident #6) Findings include: Resident #6's record was reviewed on 8/16/12 at 9:00 a.m. Resident #6's diagnoses included but were not limited to fracture of both shoulders and post traumatic wound infection. Resident #6's MDS (Minimum Data Set) assessment, dated 7/13/12, indicated Resident #6 scored 15, on the BIMS (Brief Interview for Mental Status), with a score of 13-15 indicating cognition intact. Resident #6's physician's order, dated 7/12/12, indicated "Lomotil (antidiarrheal) give 2 tablets, by mouth, every 6 hours, as needed for loose stools." During an interview on 8/16/12 at 10:46 a.m., Resident #6 indicated he still had a hospital gown on because he had diarrhea yesterday and got all his slacks dirty he stated "the stools are always just real loose like water." He also indicated he had been having at least 2 watery stools a day for a week maybe more and the CNAs were aware of the diarrhea because they have to clean him up after each stool and he has also told the nurses		483.13(c) are attached in our Plan of Correction. There has been an In-service scheduled fro 09/07/2012 that will include policy and procedure regarding MD and Family notification and Resident Dignity. An In-service was held on 8/28/2012 per Risk Management concerning documentation. The inservice on 09/0702012 will include the importance of C.N.A.'s nad Nurses being aware of and reporting consistency of resident's stools so proper notification and treatment can be completed. Please contact Justin P. Vogt H.F.A., Miller's Merry Manor of Middletown, 765-354-2278 if there is a need for any more information F –Tag 157 Notify of Changes I. To correct the deficient practice for the residents in this facility, nursing staff will be inserviced regarding appropriate notification of MD and family for any condition changes. Resident # 6 was discharged to home on August 26, 2012 after a successful rehabilitation stay. He was free from any diarrhea symptoms at time of discharge. II. Any resident that resides in this facility has the potential to be effected by this deficient practice. III. To ensure that the deficient practice does not recur, the facility will inservice the licensed nursing staff on 9/7/12 to discuss	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about his diarrhea, but he has not been offered any medication for the diarrhea. During an interview on 8/16/12 at 11:52 a.m., CNA #1 indicated it was not new for Resident #6 to have diarrhea. She stated "he has had it several days in a row since at least last Saturday (8/11/12)." During an interview on 8/16/12 at 11:55 a.m., LPN #2, indicated she was aware Resident #6 had diarrhea sometimes. During an interview on 8/20/12 at 10:00 a.m., Resident #6's family member indicated Resident #6 told him that he had water, loose stools for over a week and that he (family member) told the nurses and the CNAs. He also indicated the CNAs would have to know because Resident #6 can not clean himself after he has a bowel movement. The following is the only documentation of diarrhea stools from 7/11/12 until present: Resident #6's, nursing notes, dated 7/11/12 at 3:23 p.m., indicated "call out to (Physician) to report diarrhea stools times 3 days"		the policy and procedure for notification of MD and family with any change of condition. IV. The corrective action will be monitored to ensure the deficient practice will not recur by use of the Notification of Change of Condition (Attachment A) Quality Assurance tool. This tool will be completed weekly per the DON or designee for 4 weeks, then monthly for 6 months and then quarterly thereafter. The QA committee will review the results and make further recommendations as needed. V. The systemic changes will be made by 09/ 07 /12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #6's, "Assessment of Pertinent Information," dated 7/11/12, Gastrointestinal, "bowel status, diarrhea (watery stool) present and abdomen soft not distended." Resident #6's, "Assessment of Pertinent Information," dated 7/12/12, Gastrointestinal, "bowel status, diarrhea (watery stool) present and abdomen soft not distended." Resident #6's, "Assessment History Response," dated 8/11/12, indicated "resident states he had two diarrhea stools today as he toilets himself, simply stated that stool was runny" Resident #6's, nursing notes, dated 8/16/12 at 2:27 p.m., indicated "spoke with resident regarding complaints of episodes of diarrhea stools. Have not observed resident toilet self this shift. He reports that he had two stools this morning. Offered antidiarrheal medication, resident states he does not need it. Explained to resident that if he has further episodes to save and inform staff." During an interview on 8/20/12 at 1:02 p.m., the DON (Director of Nursing) indicated no medication or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	further assessment was completed after the 2 runny stools on 8/11/12 because they don't do anything unless the resident has more than 2 runny stools. She also indicated the family or physician had not been informed of the loose watery stools Resident #6 had experienced after the call to the physician on 7/11/12. 3.1-5(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure a resident was provided clean slacks in order for the resident to attend activities and use the bathroom independently for 1 of 1 residents reviewed from the sample of 19 who met the criteria for dignity. (Resident #6) Findings include: Resident #6's record was reviewed on 8/16/12 at 9:00 a.m. Resident #6's MDS (Minimum Data Set) assessment, dated 7/13/12, indicated Resident #6 scored 15, on the BIMS (Brief Interview for Mental Status), with a score of 13-15 indicating cognition intact. During an observation on 8/16/12 at 11:05 a.m., Resident #6 was observed in bed wearing a hospital gown and the gown did not cover his brief.	F0241	F – 241 Dignity and Respect of Individuality I. To correct the deficient practice for the residents in this facility, staff will be educated in regards of quality of life and dignity. Resident # 6 was discharged to home on August 26, 2012 after a successful rehabilitation stay. II. Any resident that resides in this facility has the potential to be effected by this deficient practice. All residents in the facility have been checked for sufficient clothing. All are adequate. There is a system in place to ensure they get clothing if needed. III. To ensure that the deficient practice does not recur, the facility will have a nursing inservice on 09/07/12 to discuss the policy and procedure for quality of life – dignity review. IV. The corrective action will be monitored to ensure the deficient practice will not recur by use of the Quality of Life – Dignity Review (Attachment B) Quality Assurance tool. This tool will be completed weekly per the DON or designee for 4 weeks, then monthly for 6 months, and then quarterly thereafter. The QA committee will review the results and make further	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with Resident #6 on 8/16/12 at 11:10 a.m., he indicated he could not go to the sing-a-long they were having in activities at this time because his pants were all dirty from having diarrhea yesterday and he didn't have any clean pants to wear. He also indicated he had been using his urinal because he didn't want to get up to the bathroom without his pants on. During an interview with CNA #1 on 8/16/12 at 11:48 a.m., CNA # 1 indicated Resident #6 has had diarrhea several days in a row and that is why he doesn't have any clean pants. CNA # 1 indicated she would go to the laundry and get him clean pants. During an interview on 8/17/12 at 1:02 p.m., Laundry staff #3, indicated Resident #6's pants were all dirty "but I took the clean pants back to his room yesterday afternoon. Sometimes it happens some of the residents run out of cloths but this does not happen too often." 3.1-3(t)		recommendations as needed. V. The systemic changes will be made by 09/07/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	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. Based on interview and record review, the facility failed to report or treat 1 resident's continued, loose, watery diarrhea for 1 of 11 residents reviewed that met the criteria for quality of care. (Resident #6) Findings included: Resident #6's record was reviewed on 8/16/12 at 9:00 a.m. Resident #6's diagnoses included but were not limited to fracture of both shoulders and post traumatic wound infection. Resident #6's MDS (Minimum Data Set) assessment, dated 7/13/12, indicated Resident #6 scored 15 on the BIMS (Brief Interview for Mental Status), with a score of 13-15 indicating cognition intact. Resident #6's ability to transfer, to walk in the room and the corridor was with extensive assistance. The MDS also indicated Resident #6 was occasionally incontinent of bowel and bladder.	F0309	F – Tag 309 Provide Care/Services for Highest Well Being I. To correct the deficient practice for these residents the facility will educate the licensed nursing staff on appropriate bowel assessments and necessary treatments thereof. Resident # 6 was discharged to home on August 26, 2012 after a successful rehabilitation stay. He was free from any diarrhea symptoms at time of discharge. II. Any resident has the potential to be effected by this deficient practice. III. To ensure the deficient practice does not recur, the facility will have a nursing inservice on 09/07/12 to discuss abnormal bowel assessments and necessary treatments. The inservice will include the importance of aides and nurses being aware of and reporting consistency of residents stools so proper notifications and treatments can be done. IV. The corrective action will	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #6's physician's order, dated 7/12/12, indicated "Lomotil (antidiarrheal) give 2 tablets, by mouth, every 6 hours, as needed for loose stools." During an interview on 8/16/12 at 10:46 a.m., Resident #6 indicated he still had a hospital gown on because he had diarrhea yesterday and got all his slacks dirty he stated "the stools are always just real loose like water." He also indicated he had been having at least 2 watery stools a day for a week maybe more and the CNAs were aware of the diarrhea because they have to clean him up after each stool and he has also told the nurses about his diarrhea, but he has not been offered any medication for the diarrhea. During an interview on 8/16/12 at 11:52 a.m., CNA #1, indicated it was not new for Resident #6 to have diarrhea. She stated "he has had it several days in a row since at least last Saturday (8/11/12)." During an interview on 8/16/12 at 11:55 a.m., LPN #2, indicated she was aware Resident #6 had diarrhea sometimes.		be monitored to ensure the deficient practice will not recur by use of the Bowel Assessment (abnormal) (Attachment C) and the Bowel Assessment and Treatment (Attachment D) Quality Assurance tool. This will be completed by the DON or designee weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. The QA committee will review the results and make further recommendations as needed. V. The systemic changes will be made by 09/07/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/16/12 at 12:20 p.m., with the Social Service Director, the Director indicated the resident has good balance and does not have a problem with ambulation and the reason he is not able to go home at this time is he can't clean himself after he has a bowel movement. "Occupational Therapy is working on adaptive equipment to aid him with that task and he should be able to go home soon." During an interview on 8/20/12 at 10:00 a.m., Resident #6's family member indicated Resident #6 told him that he had watery, loose stools for over a week and that he (family member) told the nurses and the CNAs. He also indicated the CNAs would have to know because Resident #6 can not clean himself after he has a bowel movement. The following is the only documentation of diarrhea stools from 7/11/12 until present: Resident #6's nursing notes, dated 7/11/12 at 3:23 p.m., indicated "call out to (Physician) to report diarrhea stools times 3 days" Resident #6's "Assessment of Pertinent Information," dated 7/11/12,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Gastrointestinal, "bowel status, diarrhea (watery stool) present and abdomen soft not distended." Resident #6's "Assessment of Pertinent Information," dated 7/12/12, Gastrointestinal, "bowel status, diarrhea (watery stool) present and abdomen soft not distended." Resident #6's "Assessment History Response," dated 8/11/12, indicated "resident states he had two diarrhea stools today as he toilets himself, simply stated that stool was runny" Resident #6's nursing notes, dated 8/16/12 at 2:27 p.m., indicated "spoke with resident regarding complaints of episodes of diarrhea stools. Have not observed resident toilet self this shift. He reports that he had two stools this morning. Offered antidiarrheal medication, resident states he does not need it. Explained to resident that if he has further episodes to save and inform staff" During an interview on 8/20/12 at 1:02 p.m., the DON (Director of Nursing) indicated no medication or further assessment was completed after the 2 runny stools on 8/11/12 because they don't do anything			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unless the resident has more than 2 runny stools. Resident #6's "Bowel Movement Report" indicated the following bowel movements: 7/11/12, 1 medium 7/12/12, 1 medium 7/13/12, 1 medium 7/14/12, 3 medium 7/15/12, 1 medium 7/16/12, 2 medium 7/17/12, 1 medium 7/18/12, 1 medium 7/19/12, 1 small and 1 large, 7/20/12, 0 7/21/12, 2 medium 7/22/12, 0 7/23/12, 1 small, 7/24/12, 1 medium 7/25/12, 2 medium 7/26/12, 2 medium 7/27/12, 0 7/28/12, 0 7/29/12, 1 extra large 7/30/12, 1 medium 7/31/12, 1 medium 8/1/12, 0 8/2/12, 0 8/3/12, 1 large 8/4/12, 2 medium, 8/5/12, 1 large and 2 medium 8/6/12, 1 medium, 8/7/12, 1 extra large 8/8/12, 1 medium			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/9/12, 2 medium 8/10/12, 2 extra large, 1 medium and 1 small 8/11/12, 1 extra large, 1, large and 1, medium 8/12/12, 1 extra large and 1 large 8/13/12, 1 medium, 8/14/12, 2 large 8/15/12, 2 medium 8/16/12, 1 medium There was no description of the consistency of the bowel movements. Resident #6's MAR (Medication Administration Record) indicated Resident #6 had not received Lomotil for July or August, 2012. 3.1-37(a)			