STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F000000	This visit was for a Recertification Survey and State Licensure. Survey Dates: 8/24, 8/25, 8/26, & 8/27/2014 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Survey Team: Gwen Pumphrey, RN (TC) Gloria Reisert, MSW Jennifer Sartell, RN Trudy Lytle, RN Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 4 Medicaid: 40 Other: 13 Total: 57 These deficiencies also reflect state findings cited in accordance with 410 AIC 16.2.-3.1. Quality Review on 9/5/14, by Brenda	F000000		

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.

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	Meredith, RN.			
F000241 SS=E	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 residents dignity was maintained during meals by not serving all residents at the seated together at the same time. This deficient practice occurred during 2 of 2 dining observations and had the potential to affect 47 of 57 residents whom typically eat in the dining room. Findings include: On 8/24/14 at 4:42 p.m., staff began to serve the dinner meal in the dining room. One staff member was observed to serve one resident at table one. A second staff member was observed to serve one resident at table two. At table three, one resident was served. At table five one resident was served. On 8/24/14 at 5:00p.m., table six was the first table in which all four residents seated were served at the same time. At table seven, one resident was served. At table 10, two residents were served. On 8/24/14 at 5:18p.m., all residents in the dining room	F000241	Residents have not displayed or verbalized any adverseeffects to trays not being served at the same times. All residents had the potential to beaffected but as above there have been no voiced or noted complaints. Dietary staff is sorting diet cards per thedining room seating chart. When traysare being put in the carts to go to the dining room there is a space in traysbeing left to indicate a new table is starting. Nursing staff has been instructed since exit conference to ensure allresidents at a table have their trays before going to the next table. The attached QA sheet will be utilized by anadministrative staff person during lunch and supper 5 days a week for 4 weeksthen 3 days a week for 4 weeks then 1 day a week for 4 weeks. If accuracy is 95% or greater at this pointthen QA will be discontinued, if less than 95% QA will continue until 95%accuracy is achieved. Addendum: After the 12 weeks of QA above the QA will continue indefinitely at 1 meal a week The meal will not be the same meal or	09/24/2014

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	were served. On 8/25/14 at 1207p.m., the lunch meal in the dining room was observed. Four of five residents at table two was served. At 12:25p.m., the second cart arrived to serve the remaining residents. Three of four residents were served at table eleven, three of four residents were served at table ten, and three of four residents were served at table nine. At 12:41p.m., all residents in the dining room were served. On 8/26/14 at 4:15p.m. the Director of Nursing provided a copy of the seating arrangement for the dining room. Eight tables were for residents able to eat independently. Three tables were four residents who required assistance with meals. Ten residents were lists as residents who preferred to dine in their room. In an interview with the Dietary Manager on 8/26/14 at 12:45 p.m, she indicated, " The reason we went to this new system for meal tray service was because there was so many issues with people being served but not everyone at the same time at the table. We served dining room trays first then the go backs (room trays) and we make up an entire table's trays before moving onto the next table. Staff are not supposed to be moving from table to		same day of the week when completed, it will be at random but at least one meal a week	

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	table before an entire table is completed first. " 3.1-3(t)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, facility failed to consistently document a residents' meal and fluid intake. This deficient practice effected 1 of 4 sampled residents reviewed for nutrition. (Resident #12) Findings include: The clinical record for Resident #12 was reviewed on 8/26/14 at 9:00 a.m. Diagnoses included, but were not limited to diabetes mellitus, hypertension, multiple sclerosis, Parkinson's disease	F000514	There is no corrective action that can be done for thisresident as food/fluid intake cannot be entered on form at this time. As with the affected resident there is nocorrective action that can be done at this time in regards to previousfood/fluid intakes. New processes willbe implemented as follows. Medicalrecords rep. or designee will review intake sheets to ensure % of food/fluidintake is being documented. Medicalrecords or designee will collect intake sheets weekly and calculate averages offood/fluid intake for the week. Dietician will be given	09/24/2014

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	and hypertension. The Minimum Data Set assessment, dated 6/16/14, indicated Resident #12 had a Brief Interview of Mental Status (BIMS) of 13, required supervision with eating after set-up. The Admission Assessment Record indicated diet the consistency to be regular with no obvious problems; admission weight was 131.5 lbs (pounds). On 8/26/14 at 9:55 a.m., review of the document titled "Vital Signs and Weight Record" indicated Resident #12 weights as follows: 6/9/14 - 131.5 lbs (admission weight) 7/1/14 - 117.3 lbs 7/29/14 - 108 lbs 8/3/14 - 107.2 lbs The Nutrition Assessment completed by facility consultant dietician on 6/18/14 was reviewed on 8/26/14 at 10:40 a.m. It indicated Resident #12's admission weight was 131.5 lbs and weight on 6/15/14 was 129 lbs. Summary of diet history indicated regular diet, 80-100% meals, no new labs, no signs or symptoms of dehydration, weight stable at 129 lbs and to continue POC (Plan of		calculations of intakes to review when in forconsulting every 2 weeks. The attachedsheet will be utilized by medical records rep or designee to calculate averagesweekly and this will be an ongoing process with no stop date. The attached QA sheet will be used by medicalrecords rep or designee when reviewing intake sheets 3 times a week for 4 weeksthen 1 time a week for 4 weeks (this will include previous days not yetreviewed, ie: Monday will review Friday,Saturday, Sunday) If 95% accuracy is achievedat this time then QA will stop if not received then QA will continue until 95%is achieved.	

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	Care). It also indicated estimated daily nutritional needs as follows: Calories: 1494-1791 Protein: 60-71 grams Fluid: greater than or equal to 1494 ml On 8/26/14 at 11:00 a.m., the meal intake sheet, dated 6/10/14 through 7/14/14, was reviewed for Resident #12 which lacked meal intake documentation for 22/35 breakfast meals served, 21/35 lunch meals served and 24/35 dinner meals served. On 8/26/14 at 11:30 a.m. the "EATSHEET," dated 6/10/14 through 7/14/14, was reviewed for Resident #12 and lacked meal documentation for 8/35 breakfast meals served, 7/35 lunch meals served and 13/35 dinner meals served. On 8/26/14 at 11:30 a.m. the "EATSHEET," dated 6/10/14 through 7/25/14, was reviewed for Resident #12 and lacked fluid intake documentation for 32/46 days reviewed for fluid intake. It also indicated Resident #12 consumed the dietary recommended amount of fluid intake for 1/46 days. During an interview with the Dietary Manager on 8/27/14 at 10:15 a.m., she indicated the consultant dietician gets her			

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	information for the nutrition assessment from the food and fluid information on the 'EATSHEETS" on the hall. She also indicated those sheets were filled out by the CNA's (Certified Nursing Assistants). 3.1-50(a)(1)			