STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155617	A. BUILDING 00 / B. WING	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	524 ANDERSON RD CHESTERFIELD, IN 46017

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00199245 . Complaint IN00199245 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323. Survey dates: May 4 and 5, 2016. Facility number: 000524 Provider number: 155617 AIM number: 100267090 Census bed type: SNF: 2 SNF/NF: 48 Total: 50 Census payor type: Medicare: 5 Medicaid: 38 Other: 7 Total: 50 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on May 9, 2016.	F 0000	Ms. Deb Barth, Please accept the following Plan Of Correction as credible allegation of compliance to the deficienceies cited at our facility during a complaint survey conducted on May 4-5, 2016. If you have any questions or need further information, please do not hesitate to contact me here at the facility at 765-378-213 Respectfully, Troy Clements, Administrator	

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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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure care plan interventions were followed as written. This deficient practice resulted in a fall with injury for 1 resident in a sample of 3. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/4/16 at 7:29 a.m. The diagnoses for Resident B included, but were not limited to, Parkinson's disease, Alzheimer's, hypertension, affective mood disorder and anxiety. The most current significant change Minimum Data Set (MDS) assessment, dated 2/15/16, was reviewed on 5/4/16 at 7:29 a.m. Resident B received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 2 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist and toileting - extensive assist with 2 person physical assist. Resident B had impaired	F 0282	F 282Services by Qualified Persons/Per care plan It is the policy of Miller's Merry Manor to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate. The facility failed to have fall prevention interventions in place as indicated on the careplan. All residents have the potential to be affected by this deficient practice. An audit was completed on all residents' fall prevention interventions and all care planned interventions are in place. All Nursing staff will be in-serviced on the Fall Management Procedure (Attachment 1A) and the Care Plan Development & Review Policy (Attachment 1B) on May 20th, 2016. The corrective action will be monitored using the QA Tool titled Care Plan / Fall Prevention (Attachment 1C). This will be completed by the DON or designee 3 times a week for 2 weeks then weekly for 4 weeks then monthly thereafter. Any issues identified will be corrected immediately and logged	05/31/2016

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	range of motion in the upper extremities on 1 side. Review of Resident B's current care plans indicated the following: "Fall Risk characterized by risk factors: dx (diagnosis) weakness and debility, confusion, dementia, hx (history) of falls, use of assistive devices, use of psychotropic [sic] meds, use of diuretics, unsteady gait, res (resident) has poor safety awareness and is impulsive at times. Will not use call light consistently to request staff assist." This care plan was dated 11/12/15. The goal indicated for Resident B's risk factors would be reduced in an attempt to avoid significant injury related to falls. This goal was dated 11/12/15. Interventions included, but were not limited to, "Non skid strips applied to floor next to bed." This was dated 11/24/15. "Non skid socks to be worn when in bed." This intervention was dated 4/21/16. "Call light in reach. Explain use of it upon admission and reinforce as needed." Review of the incident report, dated 4/28/16, indicated staff heard a loud crash and then Resident B was heard yelling and moaning. Staff entered the		on a QA Summary log. The QA summary logs are reviewed in the facility monthly QA meeting. Any new recommendations will be implemented and monitored for ongoing compliance. Corrective action will be completed by May 31st.	

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	room to find Resident B on the floor on her right side with her right arm above her head and her back against the wall. Resident B had a hematoma to the right eyebrow area and complained of pain in the right arm and shoulder, hip and leg. Resident B was also noted "going in and out of consciousness". The physician was notified and Resident B was transported to a hospital emergency room for evaluation and treatment. Resident B was not wearing non skid socks at the time of the fall and the call light was located behind the head of the bed out of reach of the resident. Review of the hospital records, on 5/5/16, indicated Resident B had sustained a nondisplaced mildly comminuted fracture of the humeral neck in the right shoulder. During an observation on 5/4/16 at 9:42 a.m., Resident B was resting in bed on her back. No nonskid socks were present. During an interview on 5/4/16 at 6:34 a.m., BNA #5 indicated the following: " I was in the other hall and came to get report from the nurse. We heard a scream. We ran down there to see who it was coming from." BNA #5 indicated staff did not move Resident B and called			

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	911. During an interview on 5/5/16 at 9:10 a.m., the Director of Nursing indicated Resident B should have been wearing the non skid socks while in bed as written in the care plan. No other information was provided. This Federal tag relates to Complaint IN00199245. 3.1-35(g)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident was free from falls for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/4/16 at 7:29 a.m. The diagnoses for Resident B included, but	F 0323	F323 Free of Accident Hazards/Supervision/Devices It is the policy of Miller's Merry Manor to assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate. The facility failed to have fall prevention interventions in place as indicated on the careplan. All residents have the potential to be affected by this deficient practice. An audit	05/31/2016

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 524 ANDERSON RD CHESTERFIELD, IN 46017	

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	were not limited to, Parkinson's disease, Alzheimer's, hypertension, affective mood disorder and anxiety. The most current significant change Minimum Data Set (MDS) assessment, dated 2/15/16, was reviewed on 5/4/16 at 7:29 a.m. Resident B received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 2 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist and toileting - extensive assist with 2 person physical assist. Resident B had impaired range of motion in the upper extremities on 1 side. Review of Resident B's current care plans indicated the following: "Fall Risk characterized by risk factors: dx (diagnosis weakness and debility, confusion, dementia, hx (history) of falls, use of assistive devices, use of psychotropic [sic] meds, use of diuretics, unsteady gait, res (resident) has poor safety awareness and is impulsive at times. Will not use call light consistently to request staff assist. This care plan was dated 11/12/15. The goal indicated for Resident B's risk factors would be reduced in an attempt to avoid significant injury related to falls.		was completed on all residents' fall prevention interventions and all care planned interventions are in place. All Nursing staff will be in-serviced on the Fall Management Procedure (Attachment 1A) and the Care Plan Development & Review Policy (Attachment 1B) on May 20th, 2016. The corrective action will be monitored using the QA Tool titled Care Plan / Fall Prevention (Attachment 1C). This will be completed by the DON or designee 3 times a week for 2 weeks then weekly for 4 weeks then monthly thereafter. Any issues identified will be corrected immediately and logged on a QA Summary log. The QA summary logs are reviewed in the facility monthly QA meeting. Any new recommendations will be implemented and monitored for ongoing compliance. Corrective action will be completed by May 31st.	

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	This goal was dated 11/12/15. Interventions included, but were not limited to, "Non skid strips applied to floor next to bed." This was dated 11/24/15. "Non skid socks to be worn when in bed." This intervention was dated 4/21/16. "Call light in reach. Explain use of it upon admission and reinforce as needed." Review of the incident report, dated 4/28/16, indicated staff heard a loud crash and then Resident B was heard yelling and moaning. Staff entered the room to find Resident B on the floor on her right side with her right arm above her head and her back against the wall. Resident B had a hematoma to the right eyebrow area and complained of pain in the right arm and shoulder, hip and leg. Resident B was also noted "going in and out of consciousness". The physician was notified and Resident B was transported to a hospital emergency room for evaluation and treatment. Resident B was not wearing non skid socks at the time of the fall and the call light was located behind the head of the bed out of reach of the resident. Review of the hospital records, on 5/5/16, indicated Resident B had sustained a nondisplaced mildly			

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	comminuted fracture of the humeral neck in the right shoulder. During an observation on 5/4/16 at 9:42 a.m., Resident B was resting in bed on her back. No nonskid socks were present. During an interview on 5/4/16 at 6:34 a.m., BNA #5 indicated the following: " I was in the other hall and came to get report from the nurse. We heard a scream. We ran down there to see who it was coming from." BNA #5 indicated staff did not move Resident B and called 911. During an interview on 5/5/16 at 9:10 a.m., the Director of Nursing indicated Resident B should have been wearing the non skid socks while in bed as written in the care plan. No other information was provided. This Federal tag relates to Complaint IN00199245. 3.1-45(a)(1)			