

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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	<p>This visit was for the Investigation of Complaint IN00108192.</p> <p>Complaint IN00108192 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey date: May 16, 2012</p> <p>Facility number: 000020 Provider number: 155059 AIM number: 100288690</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 53 Total: 62</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 9 Total: 62</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
-------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750		
(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	
	Quality review 5/21/12 by Suzanne Williams, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
F0323 SS=D	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the environment in the secured unit was free of accident hazards related to tools, and supervision was provided to prevent 1 (Resident A) resident in a sample of 3, reviewed for wandering risks, to remove a window screen and elope.</p> <p>Findings include:</p> <p>During the 5/16/12, 1:10 P.M., environmental tour of the secured unit, the Director of Nursing (DoN) indicated Resident (A) had lifted a window screen out and eloped two weeks ago on a Sunday, 5/7/12.</p> <p>The DoN indicated Resident (A) was out of the facility for 15 minutes and was found on a road 300 feet off the grounds.</p> <p>Registered Nurse (RN #1), who was on duty in the secured unit 5/7/12, was interviewed at 1:45 P. M., 5/16/12. RN #1 indicated Certified Nursing Assistant (CNA #1) was gathering residents for lunch, was unable to locate</p>	F0323	<p>It is the policy of Miller's Merry Manor to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident (A) did not incur any injury because of the deficient practice and remains in the facility on the secured unit. Resident (A) has remained on 15 minute checks. Psych consult was completed and resident was recommended to be started on anti-depressant. Care plans have been held with family to develop plan to have increased activities and family involvement for resident.</p> <p>All residents in the facility that are an elopement risk have the potential to be effected by this deficient practice.</p>	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>Resident (A), and asked if I knew his whereabouts.</p> <p>RN #1 indicated she went to the room of Resident (A) and saw the window screen leaning against a wall.</p> <p>RN #1 indicated the window was slid almost shut. RN #1 indicated she had staff in the intermediate unit page the code for elopement, had CNA #1 remain with the other 12 residents in the unit, and went to her car to search the area.</p> <p>RN #1 indicated half of the facility staff searched inside, while the other half looked about the grounds.</p> <p>RN #1 indicated CNA #2 spotted Resident (A) on a road adjacent to the grounds and pointed in that direction. RN #1 indicated she drove her car along side Resident (A), told him she was responsible for him, and could loose her job if he did not return. RN #1 indicated Resident (A) got into the car as the police arrived. RN #1 indicated staff members returned Resident (A) to the secured unit. RN #1 indicated Resident (A) was assessed without injury and was taken to the dining room for lunch.</p> <p>RN #1 indicated the Administrator was notified and Resident (A) was placed on 1:1 supervision for 24 hours, then every 15 minute observation checks.</p> <p>RN #1 indicated Resident (A) was high functioning, had a military back ground</p>		<p>Care plans of all residents identified as risk for elopement have been reviewed and updated as needed to ensure appropriate interventions are in place for prevention of elopement. Nursing staff will monitor those residents identified as elopement risks upon admission or return from LOA to ensure that no items are brought into the facility that could potentially be hazardous to the health and well being. This will be documented in the EMR (Electronic Medical record) To ensure care plans include prevention interventions for elopement risk residents and the monitoring of residents to prevent them from bringing hazards into facility, the nursing staff will be in serviced on June 7 th regarding these issues. The corrective action will be monitored by DON or designee using Q/A tool Attachment (A). This will be completed weekly for one month, every two weeks for one month and quarterly thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>and a habit of walking 1 mile a day prior to his 5/1/12, admission. RN #1 indicated a psychiatric evaluation was ordered.</p> <p>Maintenance Director #1 was interviewed 5/16/12, at 2:00 P.M., and indicated he had been called in on Sunday, 5/7/12, and had checked all windows in the secured unit. Maintenance Director #1 measured the window in the secured unit dining room and indicated all windows on the unit were uniform. Maintenance Director #1 measured the double hung windows. Each was 35 inches along the bottom track and 5 feet high.</p> <p>Maintenance Director #1 indicated all windows had a hexhead screw placed in the track, six inches from the double hung connection, which limited the area which could be opened.</p> <p>Maintenance Director #1 indicated following the 5/7/12, elopement, a second hexhead screw was placed immediately at the window edge, one in the latch lock space, and one in the upper track, in all rooms as added security.</p> <p>Maintenance Director #1 indicated the hexhead screws required a socket ratchet for removal.</p> <p>Maintenance Director #1 indicated the room of Resident (A) had been searched following the 5/7/12, elopement, and nothing was found.</p>		<p>Resident room and common resident area windows will be secured to prevent elopement. Maintenance staff was instructed to secure facility windows in secure unit immediately to prevent elopement, completed 5/7/12. Maintenance staff was instructed to secure all resident area windows thorough the facility, completed 5/8/12. Continued compliance will be monitored by administrator or designee using Q/A tool Attachment (A), compliance will be monitored daily for 7 days, weekly for 4 weeks and then monthly.</p> <p>Any concerns noted on audit tools will be addressed immediately .Tools will be reviewed in the monthly Q/A meeting.</p> <p>Completion date 6/8/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>CNA #1 was interviewed at 2:15 P.M., 5/16/12, and indicated she had weighed Resident (A) and was escorting him to the dining room for lunch when he said he was going to his room to the toilet. CNA #1 indicated she continued gathering residents for lunch, then went to the room and knocked on the door twice before entering. CNA #1 indicated she had also knocked on the bath room door twice prior to entering, then noticed the window screen against the wall and a screw on the ledge. CNA #1 indicated she immediately obtained RN #1. CNA #1 indicated the window was shut and she believed Resident (A) had removed the screen, climbed out the window, then closed it behind him. CNA #1 indicated Resident (A) had been dressed in jeans and sneakers and had taken a jacket with him. CNA #1 indicated Family Member #1 had arrived after Resident (A) was returned to the facility. CNA #1 indicated Family Member #1 had requested a key ring from Resident (A) and took it with her.</p> <p>Family Member #1 was interviewed by telephone at 2:40 P.M., 5/16/12, and indicated Resident (A) had been wandering from home prior to his admission. Family member #1 indicated the car keys had been taken from Resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>(A) when he was home and he was always searching for them. Family Member #1 indicated the physician had suggested giving Resident (A) a set of unused keys that did not open anything. Family Member #1 indicated the key ring had a military, "John Wayne can opener attached."</p> <p>Family Member #1 indicated the can opener was a miniature version of an old fashioned manual style and could have been used to remove the window screw.</p> <p>Family Member #1 indicated they had forgotten about the key ring when he was admitted to the facility.</p> <p>The Administrator was interviewed at 2:50 P.M., 5/16/12, and indicated he had not been aware of the presence of a can opener. The Administrator indicated following the 5/7/12, incident, the facility had put a monitoring procedure in place to assure the window screws were in place in each room in the secured unit.</p> <p>The record of Resident (A) was reviewed at 3:00 P.M., 5/16/12, and indicated a 5/1/12, admission.</p> <p>Diagnoses included dementia, depression, and diabetes.</p> <p>Resident (A) was assessed as a 12/15 score (cognitively aware and able to make decisions) on the 5/8/12, initial minimum</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>data set (MDS) assessment.</p> <p>The 5/16/12, 11:45 A.M., nursing note indicated CNA #1 had gone to the room to bring Resident (A) to the dining room. CNA #1 noticed a window screen against the wall. The facility grounds were searched.</p> <p>Resident (A) had eloped out the window. A head to toe assessment was completed following his return.</p> <p>There were no injuries.</p> <p>The 4/21/12, physician's history indicated progressive dementia with wandering.</p> <p>The 5/2/12, initial elopement assessment indicated Resident (A) was at risk.</p> <p>The only care plan concern addressing the elopement risk was on 5/7/12. The 5/7/12, concern indicated Resident (A) had eloped related to going home.</p> <p>Resident (A) was observed working a jig saw puzzle in the lounge in the secured unit at 4:30 P.M., 5/16/12. Resident (A) was observed to pick 2 pieces of the puzzle from the box lid and correctly place them.</p> <p>Resident (A) was interviewed in the room at 5:00 P.M., 5/16/12, and indicated he had been tired of sitting and went out through the window. Resident (A) indicated he had used a screw driver from his key chain to loosen and twist the window screen. Resident (A) indicated</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>after climbing out, he had closed the window again.</p> <p>Resident (A) indicated he had a 60% blockage on the left side, pointing to his neck, and had a bottle of nitro tablets on the key ring also. Resident (A) indicated he wanted the nitro returned</p> <p>The Director of Nursing (DoN) was interviewed at 5:10 P.M., 5/16/12, and indicated an inventory sheet was completed by staff and a family member on admission. The DoN indicated any harmful objects were removed and sent home with family. The DoN indicated she was unaware Resident (A) had a key chain with a can opener and nitro tabs on admission.</p> <p>The facility's 3/1/05, Elopement Risk Assessment Policy, which had an expiration date of 5/9/12, was provided by the Administrator on 5/16/12.</p> <p>The purpose was to assess residents for elopement potential and assure they were free from harm at all times.</p> <p>Point #3 indicated all residents at risk would immediately have interventions placed to prevent elopement.</p> <p>Point #5 indicated nursing staff were to communicate to direct care givers through verbal report and on the CNA assignment sheets the appropriate interventions for each identified resident.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>This federal tag relates to Complaint IN00108192.</p> <p>3.1-45(a)(2)</p>			