STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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 IN00197482. This visit was in conjunction with the Recertification and State Licensure Survey. Complaint IN00197482-Substantiated. Federal /State deficiencies related to the allegations are cited at F-157, F-250, F-323, & F-309. Survey dates: April 11, 12, 13, 14, 15, and 18, 2016. Facility number: 000174 Provider number: 155274 AIM number: 100274810 Census bed type: SNF: 3 SNF/NF: 52 Total: 55 Census payor type: Medicare: 8 Medicaid: 36 Other: 11 Total: 55 These deficiencies also reflect State	F 0000		

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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on April 25, 2016.			
F 0157 SS=D Bldg. 00	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure a physician was immediately notified a resident expressed a statement of self-harm for 1 of 19 residents in the Stage 2 sample. (Resident G) Findings include: On 4/11/16 at 10:25 A.M., Resident G was observed laying in bed. The clinical record of Resident G was reviewed on 4/13/16 at 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia with behavioral disturbance. The most recent Quarterly MDS (Minimum Data Set) Assessment dated 2/23/16 indicated Resident G experienced moderate cognitive impairment and no thoughts of self-harm. A Significant Change MDS dated 3/24/16 indicated Resident G experienced severe cognitive impairment and no thoughts of self-harm. A Nursing Progress note dated 3/26/16 at	F 0157	**F157D NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** It is the policy of Miller's Merry Manor, Rockportto promptly inform the resident, consult with the resident's physician, notifythe resident's legal representative or an interested family member when thereis a significant change in the resident's physical, mental, or psychosocialstatus and/or the need to alter treatment significantly. **Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by the deficient practice?** ·Resident G – Physician was notified on3/28/2016 of resident expressing a statement of self-harm. **Howwill you identify other residents having the potential to be affected by thesame deficient practice?** ·All residents have the potential to beaffected by the alleged deficient practice. **Whatmeasures will be put into place or what systemic changes will you make toensure that the deficient practice does not recur?** ·All licensed nursing staff will bein-serviced on facility policy for Physician and Family Notification ofChanges (Attachment A) on	04/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	7:08 P.M. indicated, "Resident stated to 3 staff members 'I want to cut my throat with a knife'. HFA notified and family. Resident was put on 15 minute [minute] checks. All potentially harmful objects were removed from resident's room." The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement. A consecutive Nursing Progress note dated 3/27/16 at 4:34 P.M. indicated, "Resident stated 'I would be better off dead.' Resident's son here today and resident told son the same thing. Resident's son reassure [sic] resident that he was gonna start feeling better and not to think like that." Resident remains on 15 min checks. The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement. A consecutive late entry Nursing Progress note dated 3/28/16 at 5:04 A.M. indicated, "No concerns on this shift. 15 minute checks continue." The note lacked any documentation to indicate the attending physician was immediately notified of the self-harm statement. A consecutive Nursing Progress note		4/22/2016. ·All new condition changes will bemonitored by nurse management team by reviewing Point Click Care's 24 HourCondition Report to ensure family/responsible party and physician notification. **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·24 Hour Condition Report ReviewQA tool (Attachment B) will be utilized 5 X a week X 4 weeks, weekly X 1 month,and monthly thereafter to ensure timely and appropriate physician and familynotification. ·Any identified trends will be correctedupon discovery, documented on facility QA tracking log, and reported duringmonthly QA Committee meeting overseen by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	dated 3/28/16 at 10:42 A.M. indicated, "[name of attending physician] notified of statements made over the weekend regarding pt [patient] would be better off dead. This rn [registered nurse] request antidepressant and [name of psychiatric unit] eval [evaluation]. Awaiting response." (The attending physician was not notified Resident G expressed a statement of self-harm for 39 hours and 34 minutes). A Care Plan for, "Resident verbalized a suicidal comment. Resident will be placed on modified suicide precautions" dated 3/28/16 included, but was not limited to interventions of, "The physician will be contacted immediately regarding any change in the resident's condition." During an interview on 4/14/16 at 8:45 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate the attending physician was immediately notified Resident G expressed a statement of self-harm. The Policy and Procedure for Suicide Prevention provided by the Regional HFA (Health Facility Administrator) on 4/14/16 at 10:55 A.M. indicated, "...When residents verbalize the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	intent...an attempt at suicide..The charge nurse will notify the physician of the residents [sic] change of condition and to obtain further instructions...The physician should be contacted immediately..." This Federal tag relates to Complaint #IN00197482. 3.1-5(a)(1) 3.1-5(a)(3)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure Social Services were provided after a resident expressed a statement of self-harm for 1 of 1 resident who met the criteria for review of Social Services. (Resident G) Findings include: On 4/11/16 at 10:25 A.M., Resident G was observed laying in bed. The clinical record of Resident G was	F 0250	**F250D PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** It is the policy of Miller's Merry Manor, Rockportto identify the health-related psychosocial needs of the residents and provideservices for the identified needs. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by this deficient practice?** ·All residents have the potential to beaffected by the alleged deficient practice.	05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	reviewed on 4/13/16 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia with behavioral disturbance. The most recent Quarterly MDS (Minimum Data Set) Assessment dated 2/23/16 indicated Resident G experienced moderate cognitive impairment, and no thoughts of self-harm. A Significant Change MDS dated 3/24/16 indicated Resident G experienced severe cognitive impairment and no thoughts of self-harm. A Nursing Progress note dated 3/26/16 at 7:08 P.M. indicated, "Resident stated to 3 staff members 'I want to cut my throat with a knife. HFA notified and family. Resident was put on 15 minute checks. All potentially harmful objects were removed from resident's room." The Social Service Progress notes from 3/26/16 through 4/12/16 lacked any documentation. A Care Plan for, "Resident verbalized a suicidal comment. Resident will be placed on modified suicide precautions" dated 3/28/16 included the following interventions:		**Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?** ·All residents have the potential to beaffected by the alleged deficient practice. **Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?** ·All nursing and social services staffwill be in-serviced on Suicide Precautions Procedure (Attachment C)completion date 5/6/2016. ·MSW was re-educated on 5/9/2016 onmonitoring the 24 Hour Condition Report for social service needs as well as Stressorsthat Should be Assessed policy (Attachment D). **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·Social Service NeedsQA tool (Attachment E) will be completed by MSW weekly X 4 weeks and monthlythereafter. ·Any identified trends will be correctedupon discovery, documented on facility QA tracking log, and reported duringmonthly QA Committee meeting overseen by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	Residents [sic] room will be checked thoroughly for all potentially harmful items such as files, clippers, razor blades, sharp pointed items, aerosol cans, medications, peri-wash, aftershave, belts, scarves, etc [et cetera] and any harmful items has [sic] been removed from room and/or out of reach if resident unable to get out of bed, Diet will be ordered with disposable dishes and utensils, (if appropriate), The resident is checked q [every] 15 min and appropriate documentation made regarding the residents [sic] condition in the medical record, The physician will be contacted immediately regarding any change in the resident's condition, Refer to psych [psychiatric] services and/or clergy if appropriate. Resident transferred to [name of hospital]" During an interview on 4/14/16 at 8:45 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate Social Services were provided to Resident G after the statement of self-harm on 3/26/16.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	The Policy and Procedure for Suicide Prevention provided by the Regional HFA (Health Facility Administrator) on 4/14/16 at 10:55 A.M. indicated, "...When residents verbalize the intent...an attempt at suicide...SS [Social Service] Director will visit the resident at their earliest convenience to do appropriate interventions and documentation...The SSD [Social Services Designee] ...will do a minimum daily visit with the resident with appropriate documentation in the SS notes..." This Federal tag relates to Complaint #IN00197482. 3.1-34(a) 3.1-34 (a)(1)			
F 0309 SS=D Bldg. 00	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 observation, interview, and	F 0309	**F309D PROVIDE**	05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	record review, the facility failed to ensure staff responded to a resident's calls for help for 1 of 1 random observation of a resident calling out for help. (Resident G) Findings include: During a random observation on 4/11/16 at 10:25 A.M., Resident G was observed from the hallway through a partially opened door, laying in bed and repeatedly calling out, "Help me! Help me!" During a continuous observation through 10:45 A.M., Resident G continued to repeatedly call out "Help me!" and no staff members were observed to enter the room of Resident G. During an interview on 4/11/16 at 10:45 A.M., RN #10 was made aware Resident G was calling for help and stated, "He does that all the time, he doesn't want anything, he just does that." During an observation on 4/11/16 at 10:51 A.M., the SSD (Social Service Designee) was observed to enter the room of Resident G. The clinical record of Resident G was reviewed on 4/13/16 1:58 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia.		**CARE/SERVICES FOR HIGHEST WELL BEING** It is the policy of Miller's Merry Manor, Rockportto ensure staff respond to residents who exhibit behavioral, mental, physical,or psychosocial symptoms in a dignified manner; and maintain resident qualityof life and the safety of residents and others. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?** ·Resident G – Resident was sent out for medicalattention and has returned with no negative outcomes. **Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?** ·All residents have the potential to beaffected by the alleged deficient practice. **Whatmeasures will be put into place or what systemic changes will you make toensure that the deficient practice does not recur?** ·RN #10 was educated on 4/14/2016 onresponding promptly to residents' requests for help. ·All licensed staff were in-serviced on theneed to respond to yelling out on 4/22/2016. **Howthe corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	During an interview on 4/14/16 at 8:00 A.M., the DON (Director of Nursing) indicated no specific policy could be provided, but it is usual facility practice for staff to respond to a resident's call for help immediately. This Federal tag relates to Complaint #IN00197482. 3.1-37(a)		**deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·Resident DignityQA tool (Attachment H) will be utilized by nurse management team weekly X 4 weeksand monthly thereafter completion date 5/9/2016. ·Any identified trends will by correctedupon discovery, documented on facility QA tracking log, and reported duringmonthly QA Committee meeting overseen by the Administrator.	
F 0323 SS=E 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. A. Based on observation, interview, and record review, the facility failed to ensure a gait belt was used to properly transfer 2 of 2 residents randomly observed for transfers and 1 of 1 resident interviewed confidentially for transfers. (Resident B, Resident C, Resident D) B. Based on observation, interview, and record review, the facility failed to ensure	F 0323	**F323E FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** It is the policy of Miller's Merry Manor, Rockportto ensure safety in transfer and ambulation. To provide a point of contact and increased support from the staff andprevent injuries to staff and residents who are unable to transfer or ambulateindependently. Gail belts will be usedas indicated on	05/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	adequate supervision was provided and new, immediate interventions were implemented for 2 of 4 residents who met the criteria for review of Accidents. (Resident H, Resident E) Findings include: A. 1. During a random observation of the East 1 lounge on 4/11/16 at 9:00 A.M., CNA #5 and RN #10 were observed to not apply a gait belt, grasp the bilateral upper arms, pull Resident C into a standing position, and transfer from a recliner to a wheelchair without using a gait belt. The CNA Assignment Sheets provided by UM (Unit Manager) #1 on 4/11/16 at 10:15 A.M., indicated Resident C required the assistance of 1-2 staff for transfers. The Assignment Sheet lacked any documentation related to the use of a gait belt. A. 2. During a random observation of the East 1 lounge on 4/11/16 at 9:10 A.M., CNA and RN #10 were observed to not apply a gait belt, grasp the bilateral upper arms, pull Resident D into a standing position, and transfer from a recliner to a wheelchair without using a gait belt.		the individual's plan of care (A). Assess all residents for risk factors thatmay contribute to falling and to provide planned interventions identified bythe team as appropriate for resident use in maintaining or returning to thehighest level of physical, social, and psychosocial functioning as possible (B). **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?** ·(A). ·Resident B – Care plan and CNAassignment sheets have been update to include the use of a gait belt intransfers completion date 5/6/2016. ·Resident C – Care plan and CNAassignment sheets have been updated to include the use of a gait belt intransfers completion date 5/6/2016. ·Resident D – Care plan and CNAassignment sheets have been updated to include the use of a gait belt intransfers completion date 5/6/2016. ·(B.) ·Resident H – Laying down after meals andwhen tired was added to the health care plan and CNA assignment sheet on3/29/2016. ·Resident E – Is no longer a resident atthis facility. **Howwill you identify other residents having the potential to be affected by thesame**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	The CNA Assignment Sheets provided by UM (Unit Manager) #1 on 4/11/16 at 10:15 A.M. indicated Resident D required the assistance of 1-2 staff for transfers. The Assignment Sheet lacked any documentation related to the use of a gait belt. A. 3. During a confidential interview on 4/11/16 at 12:07 P.M. Resident B indicated staff used to transfer him/her by grasping underneath his/her arms. The Resident further indicated staff did not use a gait belt to transfer him/her. The most recent Quarterly MDS dated 1/18/16 indicated Resident B experienced no cognitive impairment. During an interview on 4/14/16 at 8:00 A.M., the DON (Director of Nursing) indicated the residents should not have been transferred by staff by grabbing underneath the arms and a gait belt should have been used. The Policy and Procedure for Gait Belt Use Procedure provided by the MDS Nurse on 4/14/16 at 12:09 P.M. indicated, "...to insure [sic] safety in transfer and ambulation. To provide a point of contact and increased support from the staff and prevent injuries to staff and resident who are unable to transfer or		**deficient practice and what corrective action will be taken?** ·All residents have the potential to beaffected by the alleged deficient practice. **Whatmeasures will be put into place or what systemic changes will you make toensure that the deficient practice does not recur?** ·All resident's fall care plans reviewedby nurse management team to ensure accuracy and appropriate interventionscompletion date 5/13/2016. ·All nursing staff were educated on the GaitBelt Use Procedure (Attachment I) on4/22/2016 and 5/6/2016. ·All licensed nursing staff werein-serviced on Fall Management Procedure (Attachment J) and Interventions/ProtocolList (Attachment K) completion date 4/22/2016. ·Interdisciplinary team will review allfalls to determine root cause and establish proper interventions. Resident's plan of care updated accordinglyand new interventions communicated to staff completion date 5/1/2016. **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?** ·Fall Risk Management ReviewQA Tool (Attachment L) will be utilized by nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	ambulate independently..." B. 1. During an observation on 4/11/16 at 3:34 P.M., Resident H was observed sitting in a wheelchair in the East 1 lounge with head down and eyes closed. During an interview on 4/12/16 at 10:02 A.M., UM #1 indicated Resident H experienced an unwitnessed fall with injury on 3/19/16 in the East 1 unit lounge by the nursing station. UM #1 indicated Resident H dozed off while sitting in a wheelchair, fell forward, and hit his head on the floor. UM #1 further indicated, a new intervention of laying Resident H down after meals if staff noticed he was drowsy, was implemented. UM #1 then indicated, Resident H was at risk to experience falls. The clinical record of Resident H was reviewed on 4/13/16 at 2:39 P.M. The record indicated the diagnoses of Resident H included, but were not limited to, Alzheimer's. The most recent Quarterly MDS dated 3/9/16 indicated Resident H experienced severe cognitive impairment, required the extensive assistance of two staff for transfers, did not have a history of falls, and had not experienced any falls during		management team for all fallsweekly X 4 weeks and monthly thereafter completion date 5/13/2016. ·Any identified trends will be correctedupon discovery, documented on facility QA tracking log, and reported during monthlyQA Committee meeting overseen by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	the previous assessment period. A Care Plan for Fall Risk dated 1/9/16 indicated the following interventions: "anti-rollback placed on W/C [wheelchair] to stabilize w/c, toilet before every supper and every 2 hours, pommel cushion to w/c to prevent sliding forward out of wheelchair, direct supervision, analyze previous resident falls to determine whether pattern/trend can be addressed, call light in reach. Explain use of it upon admission and reinforce as needed, encourage and assist with wearing non-skid foot-wear, encourage resident to use handrails or assistive devices properly, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication, monitor for changes in gait/positioning, notify MD of changes in condition, notify Therapy of changes in condition, reassess fall risk factors annually and PRN" A Care Plan for Fall Risk dated 1/30/15 indicated the intervention of "direct supervision" was discontinued. The Care Plan lacked any documentation to indicate a new intervention was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	implemented to ensure the safety of Resident H. A Nursing-Occurrence Initial Assessment dated 3/19/16 at 10:17 A.M. indicated, Resident H experienced an unwitnessed fall with injury on 3/19/16 at 10:00 A.M. The Assessment further indicated, "Resident was in wheel chair [sic] and fell out of wheelchair in hall 1 lobby. Staff members at nurses station however fall was unwitnessed..." The Assessment lacked any documentation to indicate a new, immediate intervention was implemented to ensure the safety of Resident H. A Facility-Post Occurrence IDT a fall (sic) risk(sic) Assessment dated 3/20/16 at 7:25 A.M. indicated a new intervention of "...lay resident down in bed or transfer to recliner...anytime...noted to be drowsy" During an interview on 4/18/16 at 3:15 P.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate a new, immediate intervention was implemented before 3/20/16 at 7:35 A.M. B. 2. The clinical record of Resident E was reviewed on 4/13/16 at 3:17 P.M. The record indicated the diagnoses of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	Resident E included, but were not limited to, dementia. During an observation on 4/11/16 at 8:45 A.M., Resident E was observed sitting in a wheelchair in the East 1 Unit. Resident E was observed, at that time, to have facial bruising from the forehead to the neck. During an interview on 4/11/16 at 9:00 A.M., UM #1 indicated Resident E experienced frequent falls and had experienced a fall from bed within the last 7 days. UM #1 further indicated, at that time, the 1/2 side rail was removed and the bed frame was padded as immediate interventions. The most recent Significant Change MDS dated 10/28/16 indicated Resident E experienced severe cognitive impairment required the extensive assistance of two staff for transfers, and had a history of falls. The most recent Quarterly MDS dated 2/4/16 indicated Resident E experienced severe cognitive impairment, required the extensive assist of two staff for transfers, and had experienced no falls during the previous assessment period. A Care Plan dated 3/2/16 for Falls			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 815 W WASHINGTON ST ROCKPORT, IN 47635	

(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
	indicated the following interventions: toileting schedule, night light placed in room, call light within reach when in room, encourage and assist with wearing non-skid foot-wear, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication, lip mattress, low bed with mat at bedside while in bed, bed against wall, move w/c's [wheelchairs] away from resident, notify MD of changes in condition reassess fall risk factors annually and PRN, Resident to be in common area when up in w/c Provide diversion and/or activity, Resident to be transferred from w/c to couch when in the lounge." Fall #1 A Nursing-Occurrence Initial Assessment dated 4/5/16 at 2:34 A.M. indicated, "Walking by resident's room and saw resident laying on mat by bed. States was nauseated and tried to get up...Denies injury or hitting head but has bruising around right eye" The assessment lacked any documentation to indicate a new, immediate intervention was implemented to ensure the safety of Resident E.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	An Incident Investigation dated 4/5/16 indicated Resident E experienced an unwitnessed fall on 4/5/16 at 9:30 P.M. The Investigation further indicated Resident E was toileted at 9:25 P.M., previously planned interventions were not effective and the immediate interventions implemented was, "toilet resident". The Investigation lacked any documentation to indicate a new, immediate intervention was implemented after the fall. The Nursing Progress notes from 4/3/16 at 3:02 P.M. through 4/6/16 at 10:11 A.M. lacked any documentation to indicate a new immediate intervention was implemented to ensure the safety of Resident E. A Facility-Post Occurrence IDT (Interdisciplinary Team) and fall (sic) risk (sic) Assessment dated 4/6/16 at 10:37 A.M. indicated a new intervention of, "remove 1/2 SR [side rail] and pad the entire length of the bed frame on the right side of bed" was implemented. During an interview on 4/18/16 at 3:00 P.M., the DON (Director of Nursing) indicated she did not know the exact time the side rail was removed and the bed frame was padded, but no documentation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155274		04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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
	could be provided to indicate a new, immediate intervention was implemented before 4/6/16 at 10:37 A.M. The Policy and Procedure for Falls Management provided by the HFA on 4/18/16 at 1:55 P.M., indicated, "...If a fall occurs...determine what new or revised interventions will be implemented to reduce the risk of further falls..." This Federal tag relates to Complaint #IN00197482. 3.1-45(a)			