

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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 Recertification and State Licensure Survey.</p> <p>Survey dates: January 23, 24, 25, 26 and 27, 2012.</p> <p>Facility number: 000578 Provider number: 155627 AIM number: 100267810</p> <p>Survey team: Tammy Alley, RN-TC Randy Fry, RN Linn Mackey, RN Shelly Reed ,RN Deanne Mankell, RN (1/25, 26, 27, 2012)</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 3 Medicaid: 22 Other: 3 Total: 28</p> <p>Stage 2 Sample: 23</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</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:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

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

	16.2.  Quality review completed on February 2, 2012 by Bev Faulkner, RN			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0241 SS=E	<p>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.</p> <p>Based on interview and record review, the facility failed to ensure call lights and assistance was provided to residents for toileting for 4 of 6 residents who met the criteria for having sufficient staffing in a QCLI (Quality Care Life Indicator) sample of 15, (Residents 3, 11, 22, 28).</p> <p>Findings include:</p> <p>1. An interview with Resident #3 on 1/23/12 at 11:40 A.M., indicated she had to wait quite awhile to receive assistance to go to the bathroom because she required staff assistance with a lift to transfer to the toilet. The resident said she usually had to wait a half an hour or longer at times. The resident indicated this usually happens in the middle of the morning or closer to noon. The resident indicated she has had an incontinent accident once or twice a month because of having to wait for staff assistance to get to the bathroom, especially when milk of magnesia was given. The resident indicated she had complained about this recently and the staff response to call lights had improved for awhile, but then</p>	F0241	<p>It is the policy of Miller's Merry Manor West that the facility will 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.1. Call lights will be answered within 5 minutes and assistance will be provided to residents 3, 11, 22, and 28 for care needed. Residents 3, 11, 22, and 28 were interviewed by administrator and DON and call light times were discussed.2. All residents have the potential to be affected by the same practice. All call lights will be answered within 5 minutes and assistance will be provided to all residents to meet their care needs.3. All Staff will be re-in-serviced regarding call light response time. DON or designee will begin auditing call light response time utilizing the "Call Light Response Tracker" (Attachment A) This will be completed 3 times each shift daily for 2 weeks, 2 times per shift daily for two weeks, 1 time per shift daily thereafter until issue is resolved. 4. Each month every alert, oriented, and interviewable resident will be asked monthly "QA Calls Script" (Attachment B). This form will be used indefinitely. POA or family</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>went back to being slow. Record review on 1/26/12 at 11:00 a.m., indicated this resident was interviewable as evidenced by a BIMS (Brief Interview of Mental Status) score of 12 on 11/29/11.</p> <p>2. An interview with Resident #11 on 1/24/12 at 9:18 A.M., indicated she has had to wait up to half an hour for staff to answer her call light, and said it's more of a problem on evening shift. Record review on 1/26/12 at 11:05 a.m., indicated this resident was interviewable as evidenced by a BIMS (Brief Interview of Mental Status) score of 10 on 1/10/12.</p> <p>3. An interview with Resident #22 on 1/24/12 at 8:28 A.M., indicated the facility often had only two CNA staff on duty, and the resident had an incontinence accident twice while waiting for staff assistance to the bathroom. The resident said it was more of a problem during meal times as staff were busy in the dining room. Record review on 1/26/12 at 11:10 a.m., indicated this resident was interviewable as evidenced by a BIMS (Brief Interview of Mental Status) score of 14 on 11/3/11.</p> <p>4. An interview with Resident #28 1/23/12 at 2:43 P.M., indicated the</p>		<p>member will be contacted for QA call if resident is not interviewable. Any concerns will be documented on a concern form and addressed immediately by the appropriate department head. (Attachment C) All QA Calls Scripts will be brought to the monthly QA meeting and concerns will be logged on the Quality assurance improvement summary log (Attachment D). This will reviewed in QA meeting monthly until issue is resolved. 5. All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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 felt like she had to wait for the staff to assist her to the bathroom or to transfer into in her chair because there were often only two CNAs on duty. Record review on 1/26/12 at 11:10 a.m., indicated this resident was interviewable as evidenced by a BIMS (Brief Interview of Mental Status) score of 10 on 10/26/11.</p> <p>Review of the Resident Census and Condition of Residents form on 1/25/12 at 12:50 P.M., indicated 25 residents in the facility required an assist of one or two staff for transferring, and 27 residents required an assist of one or two staff for toilet use.</p> <p>Review of the facility staffing patterns as worked the past month provided by the Director of Nursing (DoN) on 1/26/12 at 9:50 A.M., indicated for the month of December 2011 there were two CNA staff scheduled on the evening shift.</p> <p>Review of the current policy and procedure for Mechanical lift transfer dated 3/1/01, provided by the DoN on 1/26/12 at 11:00 A.M., included, but was not limited to the following: "Equipment: Mechanical lift...Two staff members (minimal)."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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>An interview with the DoN on 1/26/12 at 9:55 A.M. indicated they had some recent complaints from residents regarding slow call light response, and only after the resident census increased slightly in January did they add a third CNA from 5:00 P.M. to 9:00 P.M. to assist with answering call lights. The DoN confirmed there were 27 residents in the facility requiring one or two staff for toilet use, four residents requiring a two person assist for transferring with a lift, one resident requiring three staff to transfer using a lift, and one additional resident who required a two person assist for transferring with a lift occasionally.</p> <p>3.1-3(t)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0242 SS=E	<p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to allow 3 of 3 residents who met the criteria for choices in a QCLI (Quality Care Life Indicator) sample of 16 to choose the time they were gotten up in the morning (Residents 12, 17, and 28).</p> <p>Findings include:</p> <p>1. An interview with Resident #17 on 1/23/12 at 1:42 P.M., indicated the resident would like to stay in bed longer in the morning, but she said they have rules and "it's not their fault I have to get up earlier than I want." The resident indicated she is usually awakened and gotten up by staff around 5:00 A.M.</p> <p>This resident was interviewable as evidenced by a BIMS (Brief Interview of Mental Status) score of 13 on 11/23/11.</p> <p>An interview with CNA #3 and CNA #4 on 1/25/12 at 9:45 A.M., indicated Resident #17 was up this morning on</p>	F0242	<p>It is the policy of Miller's Merry Manor West that the facility will allow residents the right to choose activities, schedules, and healthcare consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. 1. Social Service Director met with Resident 12, 17, and 28 and asked what time they prefer to get up in the morning. Resident 12, 17, and 28 will be able to choose what time they would like to be gotten up in the morning. Changes made to the plan of care and CNA assignments. If a resident wishes to not get up that morning rights will be respected. 2. All residents have the potential to be affected. The social service director or designee has asked each resident what time they would like to be gotten up in the morning (Attachment E). Changes will be made to the plan of care and CNA assignment sheets. 3. The resident's preference will be documented in the resident's plan</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>1/25/12 when they reported for work at 6:00 A.M. CNA #4 indicated resident #17 was usually up between 5:00 and 5:30 A.M. CNA #3 and CNA #4 indicated the third shift staff usually start getting residents up around 4:30 A.M.</p> <p>2. An interview with Resident #12 on 1/23/12 at 10:30 A.M., indicated she wanted to sleep later in the morning, but the staff often got her up too early, sometimes as early as 5:00 A.M.</p> <p>An interview with CNA # 2 on 1/25/12 at 9:10 A.M., indicated Resident #12 was gotten up at 5:10 A.M., this morning, 1/25/12, because she was on the list to be gotten up early. CNA #2 indicated third shift staff usually begin getting residents up around 4:00 or 4:30 A.M.</p> <p>Review of the clinical record for Resident #12 on 1/25/12 at 2:00 P.M., included, but was not limited to the following care plan: "Focus: Resident expresses, during the assessment process, that it is important to them to choose their own clothing to wear, take care of personal belongings, choose between shower, tub, bed, or sponge bath, choose bedtime...Intervention: Determine what time resident wants</p>		<p>of care and communicated to the floor staff via the CNA communication book. 4. Each month every alert, oriented, and interviewable resident will be asked monthly "Do you feel the staff honor your preference of when to get up in the morning? Using the "QA Calls Script" (Attachment B). This form will be used indefinitely. POA or family member will be contacted for QA call if resident is not interviewable. Any concerns will be documented on a concern form and addressed immediately by the appropriate department head. (Attachment C) All QA Calls Scripts will be brought to the monthly QA meeting and concerns will be logged on the Quality assurance improvement summary log (Attachment D). This will be reviewed in QA meeting monthly until issue is resolved. 5. All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>to go to bed at night. 10:00 P.M., or later." There was no specific intervention documented to allow the resident to get up in the morning at the time of her choice.</p> <p>Review of the third shift get up list provided by the facility Administrator on 1/25/12 at 10:00 A.M., indicated both Resident # 17 and Resident #12 were on this list.</p> <p>3. The clinical record of Resident # 28 was reviewed on 1/25/12 at 2:00 p.m. The plan of care (POC) indicated Resident #28 expressed the desire to stay in bed at breakfast. Resident #28 also indicated she occasionally enjoyed having snacks in her room and eating cereal for dinner.</p> <p>Record review on 1/26/12 at 1:30 p.m., indicated the Minimum Data Set (MDS), dated 10/26/11, had the Brief Interview Mental Status ( BIMS) score of "10/15." BIMS score on the MDS, dated 9/12/11, was "11/15." These scores indicated that the resident was reliable and interviewable.</p> <p>During an interview 1/25/12 at 1:15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>p.m., Resident #28 indicated she would like to sleep in, but the staff got her up. She denied talking to anyone because she felt like things would not change. During an interview on 1/26/12 at 9:05 a.m., Resident #28 indicated she was wakened today at 6 a.m.</p> <p>During an interview on 1/26/12 at 12:45 p.m., with RN #5, she indicated Resident #28 was awakened at 6:00 a.m., for her morning blood sugar check. RN #5 indicated the resident would occasionally ask to go back to bed but was normally given morning care between 6:30 a.m. and 7:00 a.m., depending on her bath schedule.</p> <p>3.1-3(u)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0253 SS=C	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain a clean, sanitary, and comfortable environment on two of two halls. This deficit practice had the potential to affect 10 of 28 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 1/23/12 at 9:45 A.M., the following observations were made on the North Hall:</p> <p>The wallpaper had been removed along the lower walls below the handrails. There were areas where bits of wallpaper were still partially sticking to the wall. The entire area had old adhesive residue uncovered and unpainted.</p> <p>In Room 19, the bathroom ceiling vent was coated with dust, and a buildup up of dark gray and brown debris was noted along the baseboard moulding.</p> <p>In Room 16, the cove board in the bathroom was pulling away from the wall at the right side of the door.</p> <p>In Room 21 the bathroom doorway had chipped and flaking paint along</p>	F0253	<p>It is the policy of Miller's Merry Manor West that the facility provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Drywall will be applied to the wall in the North hall below the handrails. Room 19 vents will be cleaned and dust will be removed from the vents. Room 19's baseboard molding will be cleaned and debris will be removed. Room 16's cove board will be applied securely to the wall. In room 21 the bathroom doorway will be touched up and painted. Room 17's vents in the bathroom will be cleaned and dust will be removed. The west hall will have corner molding applied below the handrails. The corner molding has been ordered by the facility and an installation schedule has been set for on or about March 1st , 2012. The corner bead will be covered and paint will be touched up along the door frames. The wall paper will be applied to the drywall and will not be peeling. Room 2 will have no sharp edges exposed to the residents. Room 6 will have no sharp edges exposed to the residents. Rooms 9 and 16 will have the hand rails repaired so they are not gouged and splintered at the doorways. Room 1 will have the paint reapplied to</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>the corners.</p> <p>In Room 17, the ceiling vent in the bathroom was coated with dust.</p> <p>The West Hall doorway corners were all missing corner moulding below the handrails. The corner bead was exposed throughout the Hall, with chipped and cracked paint along the door frames. There were two areas of wallpaper peeling away from the drywall.</p> <p>Room 2 on the West Hall had a piece of metal moulding along the door frame at the handrail level with a sharp point where the metal moulding had been cut and splice. Room 6 on the West Hall had a piece of wooden door moulding that had broken leaving a splintered piece protruding 26 inches above the floor and a kick plate on the lower section of the door that was broken with a sharp piece of plastic protruding 14 inches above the floor.</p> <p>At Rooms 9 and 16, the hand rail ends were gouged and splintered at the doorways to both rooms.</p> <p>The Room 1 bathroom had chipped paint on the walls and the outside corners, and two areas where wall fixtures had been removed had holes</p>		<p>the wall to match the current color. 2. All residents have the potential to be affected by this same practice. All other resident rooms will be inspected to ensure the facility provides and maintains a sanitary, orderly, and comfortable interior.3. These environmental findings will be reviewed with staff by 2/26/12. Staff will be educated on what environmental issues to look for. Staff will report any concerns to the maintenance director or administrator immediately. 4. Each month the maintenance director or designee will use the QA tool titled Housekeeping and Maintenance Service Review (Attachment F) Any concerns will be logged on the Quality Assurance improvement summary log (Attachment D). Quality Assurance improvement summary log will be reviewed monthly at the QA committee meeting. Any issues identified as causing a potential safety hazard will be addressed immediately. This tool will be completed 2 times a month for 90 days and monthly thereafter.5. All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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>where drywall had not been filled or repainted to match the current color.</p> <p>An interview with the Maintenance Director on 1/25/12 at 8:35 A.M., indicated he was doing all the renovation by himself and had not been able to complete the work yet. He indicated he was planning to start the repairs and renovation to the North Hall next week.</p> <p>3.1-19(f)(5)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, observation and interview, the facility failed to ensure the physician orders were followed for ordered medications for 1 of 10 residents observed during medication pass. (Resident # 27).</p> <p>Findings included:</p> <p>1. During the medication pass on 1/26/2012 at 9:38 A.M., while observing RN #5, she indicated the iron medication in the medication cart was not the right medication. She had a Niferex 150 mg. to give the resident, but the order listed on the January 2012 MAR (Medication Administration Record) was FeSO4 325. She said she would not give the medication, but would check the Pixis (a medication storage device) later for the correct medication.</p> <p>Resident #27's clinical record was reviewed on 1/24/2012 at 12:31 P.M.</p> <p>Resident #27's diagnoses included, but were not limited to, chronic kidney disease, anemia, renal failure.</p> <p>Resident #27's January 2012 MAR</p>	F0282	<p>It is the policy of MMM Wabash West that services provided for or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.1. The order for the iron supplement was clarified. The pharmacy was contacted and the proper medication was sent. MAR was reviewed for accuracy. Resident #27 is receiving correct medication.2. All residents have the potential to be affected by this deficient practice. All resident medications in cart have been checked with current orders to ensure there are no discrepancies. No issues were noted.3. Inservice will be conducted for licensed nurses. Will review what to do when receiving new physician order for medications.The five rights of medication administration have been reviewed with nurses. When a medication change occurs, the old medication will be removed from the cart. The new order will be faxed to the pharmacy when received to ensure the medication is received timely.4. The DON or designee will audit all new med orders nightly to ensure that new medications have been received and that the correct medication. The QA tool Medication Changes (attachment G) will be</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>(Medication Administration Record) was reviewed on 1/16/2012 at 1:30 P.M. The MAR indicated an order for "FeSO4 325 mg (milligrams) tab (iron) give one tab per PEG (percutaneous gastrostomy tube) 2 x daily at 9 A.M. and 9 P.M. for supplement" with a start date of 1/5/2012. This medication was charted as given on 1/6/12 through 1/26/2012.</p> <p>Review of the MD orders indicated an order written on 1/5/2012 for "FeSO4 325 mg 1 tab per peg tube 2 x day at 9 AM and 9 PM."</p> <p>During an interview with RN #5 on 1/26/2012 at 2:05 P.M., she indicated she had called the pharmacy and they indicated the iron pill in the cart was the Niferex as that was the only order they had. She indicated the facility had sent the transfer form which the facility had received from the hospital and not the orders which were written on the facility physician's order form and the pharmacy told her they should not have accepted the hospital order form. She indicated the physician had changed the resident's order to FeSO4 325 mg. on the day the resident had been admitted, but the pharmacy had not gotten the physician's order form so they had been sending the Niferex.</p>		<p>completed. This tool will be completed daily for one month, then 2 times per week for 1 month, then weekly thereafter. Any identified issues will be addressed immediately and logged on the QA Improvement Summary log. (Attachment D). The QA Improvement summary log will be reviewed in the monthly QA meeting. This will continue until the QA committee deems that the issue has been resolved. 5.All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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>She indicated she had called the physician and he wanted the FeSO4 325 mg. given to the resident, so the pharmacy was going to send the correct medication and she was going to pull all of the Niferex left in the medication cart.</p> <p>During an interview with RN #5 on 1/26/2012 at 3:00 P.M., she indicated that a medication error report had been filled out by the facility. She further explained the resident was given the FeSO4 325 mg. from the EDK.</p> <p>During an interview with the Director of Nursing on 1/27/2012 at 9:30 a.m., she indicated the nurses who had been administering the medication had not been following the physician's order by not ensuring the correct medication had been administered.</p> <p>Review of the "Medication Administration Procedure," dated 12/26/2011, provided by the DON, indicated "6. Read the administration record and select the proper medication from the resident's med stock. 7. Compare the label with the administration record."</p> <p>3.1-35(g)(2)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0312 SS=D	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to ensure assistance was provided for toileting and dental hygiene for 1 of 2 residents reviewed who met the criteria for personal hygiene and toileting in a Stage 2 sample of 23. (Resident # 28)</p> <p>Findings include:</p> <p>1. During an interview on 1/25/12 at 1:15 p.m., with Resident #28 the resident indicated she did not get any assistance cleaning her teeth this morning. She did not ask for assistance on the days she does not get help because she thought it was her fault if she forgets to ask. She also indicated that the staff is "pretty good" about helping her with dental care most of the time..</p> <p>During an interview on 1/26/12 at 9:05 a.m., Resident #28 indicated that she waited on the call light to be answered this morning causing her to have become incontinent. The resident also indicated that she did not receive dental care this morning.</p>	F0312	<p>It is the policy of MMM Wabash West that all resident unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.1. Resident #28 will receive assistance with oral hygiene as indicated per plan of care.2. All residents have the potential to be affected by this deficient practice. All resident's reviewed for care needs. CNA care sheets updated as needed. Care plans reviewed and updated.3. Inservice provided to all nursing staff regarding resident care needs.CNA care sheets and care plans reviewed and updated. CNA care sheets will be reviewed and updated at least weekly by DON/Designee.4. To ensure that resident care needs are being met the facility DON/Designee will make rounds at least 2x per shift daily for 1 month, then daily per shift thereafter utilizing the QA tool "Nursing Rounds" (Attachment Any concerns identified will be addressed immediately and logged on the QA improvement summary Log (Attachment D ). This will be reviewed in the monthly QA meeting. Further monitoring utilizing this tool will be</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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>During an interview on 1/26/12 at 9:43 a.m., CNA #2 indicated that the resident is a 1 person assist. She is encouraged to walk to and from the bathroom with assistance. She also indicated that the resident was incontinent this morning and morning care was provided which included washing up, cleaning folds and dressing and also setting up dental care. CNA #2 indicated she did not think that the resident received dental care this morning.</p> <p>During an interview on 1/26/12 at 10:07 a.m., CNA #2 indicated that she started care between 7:00 a.m. and 7:30 a.m. this morning. Resident # 28 was already awake. She also indicated she does not normally do morning care, but baths for residents. She said the call light was not on and the resident was awake.</p> <p>The clinical record of Resident # 28 was reviewed on 1/26/12 at 1:30 p.m. The Minimum Data Set (MDS) included a Brief Interview for Mental Status ( BIMS) score on 10/26/11 of 10 out of 15. The (MDS) indicated the resident required extensive assistance and staff to provide weight-bearing support. The MDS indicated the resident had range of</p>		<p>determined by the QA committee. All department heads will also complete monthly QA Call Script with residents/POA (Attachment B). Any identified care issues will be addressed immediately. QA calls scripts will be reviewed monthly in the QA meeting. QA call scripts will be completed monthly indefinitely as part of the company QA program.5. All systemic changes and inservies will be completed by February 26, 2012.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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>motion impairment on one side with limitations. The BIMS score on 9/12/11 was 11 out of 15 and indicated the resident reliable and interviewable.</p> <p>3.1-38/(a)(3)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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=E	<p>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>A. Based on observation and interview, the facility failed to maintain a safe enviornment in 6 of 20 rooms and 1 of 2 halls. (Room # 19, 14, 22, 23, 2, 6, )</p> <p>B. Based on record review, and interview, the facility failed to investigate the cause of falls for 1 of 2 residents in a sample of 2 that met the criteria for accidents. (Resident # 21)</p> <p>Findings include:</p> <p>A. During the initial tour of the facility on 1/23/12 at 9:45 A.M., the following observations were made on the North Hall: There was metal corner bead exposed along the doorway to every room and a sharp metal edge unattached to the drywall was observed protruding between one and two feet above the floor at the therapy room doorway.</p> <p>The doorway to Room 19 had two nails protruding a half inch from the corner moulding, and the nursing supply room had a nail protruding a half inch from the corner moulding.</p>	F0323	<p>It is the policy of MMM Wabash West to 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. 1. The metal corner bead by the doorways to the rooms on the North Hall will be covered and attached.Nails protruding from doorway of room 19 were removed immediately.Nail protruding from corner molding of door frames in rooms 14,22 and 23 were all removed immediately.Electrical box and outlet near room 17 has been repaired and has no gap.Room 2 on West Hall was repaired where there was a piece of metal molding and a sharp point.Room 6 on West Hall was repaired where a piece of wooden molding had broken off and a kick plate that was broken off.Rooms 9 and 16 hand rail ends have been repaired. Resident #21 fall risk has been reviewed and also care plan has been reviewed. Current measures are in place for fall prevention and are appropriate.2. All residents have the potential to be affected by this deficient practice. All halls will be inspected to ensure that the resident environment remains</p>	02/26/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>Rooms 14, 22, and 23, all had a nail protruding from the corner moulding in the door frames below the hand rails.</p> <p>An electrical box and outlet near Room 17 on the North Hall was protruding from the wall leaving a half inch gap between the box cover and the drywall.</p> <p>Room 2 on the West Hall had a piece of metal moulding along the door frame at the handrail level with a sharp point where the metal moulding had been cut and spliced.</p> <p>Room 6 on the West Hall had a piece of wooden door moulding that had broken, leaving a splintered piece protruding 26 inches above the floor and a kick plate on the lower section of the door that was broken with a sharp piece of plastic protruding 14 inches above the floor.</p> <p>In Rooms 9 and 16, the hand rail ends were gouged or splintered at the doorways to both rooms.</p> <p>An interview with the Maintenance Director on 1/25/12 at 8:35 A.M., indicated he was doing all the renovation by himself and had not</p>		<p>free of any environmental safety issues. All residents at risk for falls have been reviewed along with care plans to ensure interventions are appropriate and in place to reduce the risk of falls.3. Maintenance director or designee will do routine weekly rounds to monitor for any environmental safety issues. All resident at risk for falls have been reviewed along with care plans to ensure interventions are appropriate and in place. All falls will be investigated fully utilizing the Post-Fall investigation (Attachment I). This will be completed in its entirety to ensure that all areas are reviewed which could contribute to the resident's risk and to determine the root cause for the fall.The IDT will meet and review the fall investigation and interventions put into place after each fall. The DON/Designee will then complete the Post Occurrence IDT note in the electronic medical record.4. To monitor any environmental safety issues the maintenance director will complete the QA Tool Maintenance and Housekeeping Service Review (Attachment F). This tool will be completed 2 times a month for 90 days and monthly thereafter. Any identified issues will be added to the monthly QA summary log (Attachment D). To ensure that facility protocol is followed for all falls the DON/Designee will complete the QA tool Fall Risk</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>been able to complete the work yet. He indicated he was planning to start the repairs and renovation to the North Hall next week. He indicated he was not aware of the hazards observed during the initial tour of the facility.</p> <p>B. The clinical record for Resident # 21 was reviewed on 1/23/12 at 1:30 p.m.</p> <p>Resident # 21's current diagnoses included, but were not limited to, Peripheral vascular disease, hypercalcemia, diabetes, altered mental status, macular degeneration, osteoporosis and hip fracture.</p> <p>Review of the MDS (Minimum Data Set Assessment) indicated the resident was severely cognitively impaired and rarely or never made independent decisions.</p> <p>Nurses notes, dated 6/9/11 at 7:35 p.m., indicated that Resident # 21 had a fall and that she had slid out of her wheelchair.</p> <p>A 6/10/11 IDT (Interdisciplinary</p>		<p>Management Review on a monthly basis indefinitely (attachment J). Issues identified will be placed on the monthly QA summary log. Issues will be addressed immediately. All QA tools/logs will be reviewed in the monthly QA meeting. Any unresolved issues will remain on the QA log and reviewed at the next meeting. 5. All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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>team) meeting note indicated an assessment of the resident's fall. "Resident's back against her chair sitting on buttock....attempted to get out of bed and sat down on the floor in front of the w/c... root cause... resident states she was trying to fix her tv...."</p> <p>IDT recommendations: "... re-instructed resident in not getting up and to use call light when needing assistance... resident also receiving therapy at this time..."</p> <p>A 6/17/11, 9:15 a.m., nurses note indicated the resident was found on floor in front of roommate's night stand flat on her back.</p> <p>IDT meeting notes, dated 6/20/11, for fall on 6 /17/11 indicated "...root cause trying to ambulate self... interventions added bedrest. no other new interventions added."</p> <p>Nurses notes, dated 1/14/12 at 7:15 p.m., indicated "staff heard chair alarm going off ...noted resident lying face down on floor with w/c tipped on resident ...root cause resident trying to ambulate self ...recommendations bedrest added to the current interventions."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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>IDT meeting notes, dated 1/17/12 at 2:19 p.m., indicated no investigation of medications, but recommendations to put on anti tipper on front of wheelchair.</p> <p>There was no pharmacy notes that indicated any review of medications was completed related to the falls.</p> <p>Interview on 1/27/12 at 9:20 a.m., with the D.O.N. indicated that she had not investigated the relationship of medications, hunger and thirst related to the cause of the falls. She indicated if the resident could say why they fell they did not investigate further.</p> <p>Interview with DON 1/27/12 at 12:30 p.m., indicated a post fall investigation for the fall on 6/9/11 indicated that medications were reviewed, but only indicated no change in medications or clinical status review.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

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

F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review, observation, and interview, the facility failed to ensure infection control practices were followed for 2 of 12 residents in</p>	F0441	It is the policy of MMM Wabash West to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable	02/26/2012
---------------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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 sample of 12 who were observed for direct care. (Resident # 27, # 33)</p> <p>Findings included:</p> <p>1. The clinical record for Resident # 27 was reviewed on 1/23/12 at 2:00 p.m. Diagnosis included by are not limited to, chronic kidney disease, anemia, acute brain stem infarct, hypertension, diabetic, coronary artery disease, diabetic retinopathy, an above knee amputation, chronic renal failure, abnormal folds in bladder, congestive heart failure, hypothyroidism and constipation.</p> <p>Resident # 27 was admitted to the facility with a preexisting pressure ulcers. An order, dated 1/20/12, was for the areas to be cleaned daily, with a wound cleanser and to apply Santyl (a debriding agent used to treat pressure areas) and to cover the area with gauze and secure with tape and change the dressing daily and as needed.</p> <p>On 1/24/12 at 130 p.m., an observation of a dressing change on Resident # 27 was made with LPN # 7 and LPN # 8. LPN # 7 was changing the dressing. The resident was on his side. The dressing was</p>		<p>environment and to help prevent the development and transmission of disease and infection.1. Resident #27 continues to receive routine care for pressure ulcer which was present on admission. The wound is free of s/s infection and is progressing. The medication for resident #33 was given properly. The initial capsule which was touched by the nurse was discarded and a new capsule was obtained after the nurse did have gloves on. There was no negative outcome for the resident.2. All residents have the potential to be affected by this deficient practice. No other issues have been identified.3. All nurses re-educated on dressing changes and infection control measures when passing medication.4. The DON/Designee will monitor random treatments provided to residents and medication pass 2x weekly for the next 1 month, then weekly for 1 month and then quarterly thereafter on different shifts to ensure nurses are following proper infection control measures when performing these skills. This will be completed utilizing the QA audit tools Medication Pass Procedure (attachment K) and Dressing Change/Treatment procedures (attachment L). Any issues will be addressed immediately with the nurse. Issues will be logged on the QA summary log (Attachment D) The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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>noted to have some brown drainage on the old dressing. The tape had been observed being used to tape the wound on the buttocks of Resident # 27 and the tape had touched the linens in the bed. LPN # 8 was assisting with the dressing change by holding the resident over. At the conclusion of the dressing change. LPN # 8 removed her gloves and proceeded to pick up the gauze, the tape, and other supplies and to place the dressing gauze and the tape back in the treatment cart.</p> <p>Interview with LPN #8 on 1/24/12 after the dressing change, she indicated it was the ok to place the supplies back in the treatment room.</p> <p>On 1/26/12 at 1:00 p.m., in interview with DON (Director of Nursing), she indicated that the corporate nurse indicated that it is OK to bring dressing and tape out of the room and place it in the treatment cart, if it was placed on a clean surface and not contaminated.</p> <p>2. On 1/25/12 at 9:01 a.m., LPN #6 was observed during medication pass to prepare medication for Resident #33. LPN# removed, Spiriva, a medication used to open narrowed airways, with her bare hands. She</p>		<p>QA tools and summary log will be reviewed in the monthly QA meeting.5.All systemic changes and inservices will be completed by February 26, 2012.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>then placed the medication into the Handihaler, a device used to break open capsule for inhalation. During interview with LPN # 6, after the observation of the nurse touching the Spiriva tablet, the LPN acknowledged she had handled the medication with her bare hands. The nurse disposed of the medication, gloved and opened another Spiriva to administer to the resident.</p> <p>A facility policy titled "Administering Oral Medications" and dated 2011-03-23 was received from the DON on 1/27/12 at 8:20 a.m. The policy indicated "11. Prepare the required medications: b.....Do not touch tablets with hands..."</p> <p>3.1-18(b).</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992			
(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			
F0465 SS=E	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review and interview, the facility failed to ensure the floors of the kitchen were maintained in a clean and sanitary manner for 1 of 1 kitchens. This had the potential to affect dietary staff and 28 of 28 residents.</p> <p>Findings Include:</p> <p>During the initial tour of the kitchen on 1/23/12 at 9:00 a.m., accompanied by the Dietary Manager, the tile floor by the dishwasher was cracked and had a white chalky substance under the dish machine and garbage disposal area. The entire tile floor in the kitchen had numerous pitted areas. Interview with the Dietary Manager, at this time, indicated the floor was cleaned daily. A cleaning schedule was requested at this time.</p> <p>In a interview with the Dietary Manager on 1/26/12 at 10:15 a.m., the manager indicated she was unsure how the pitted areas of the floor were cleaned and indicated that the maintenance department took care of the floor cleaning.</p> <p>In a interview with the Dietary</p>	F0465	<p>It is the policy of Miller's Merry Manor West that the facility provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.1. The kitchen floors will be maintained in a clean and sanitary manner.2. All residents have the potential to be affected by the same practice. The current kitchen floor has been shocked and cleaned. The facility has ordered new kitchen floor and an installation schedule has been set for on or about March 1 st , 2012. (Attachment M and N)3. Facility will replace the kitchen floor. A schedule has been made with White's flooring to install the new kitchen floor. Will continue with routine cleaning of kitchen floor daily to ensure it is clean and sanitary.4. Each month the dietary supervisor or designee will check the kitchen floor for cleanliness, cracks, and pitted areas using the Kitchen Floor Review (See attachment O) until the new floor is installed and concerns will be documented on the Quality Assurance Improvement Summary Log (See attachment D) Any issues identified as causing a potential safety hazard will be addressed immediately. This tool will be completed monthly until the issue is deemed resolved by the QA</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>Manager on 1/26/12 at 11:00 a.m., the Dietary Manager indicated that she had spoken with maintenance personnel and they had indicated the floor was cleaned on an as needed basis. The Dietary Manager indicated the floors had been put on the maintenance cleaning list.</p> <p>Review of the cleaning schedules provided on 1/23/12 at 2:00 p.m., indicated there was no scheduled time for cleaning the floors or that cleaning of the floor was done by the dietary staff on a daily basis.</p> <p>3.1-19(f)</p>		committee.5.All systemic changes and inservices will be completed by February 26, 2012.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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	
F0520 SS=F	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify and implement a plan of action for the identified concerns of resident choices, sufficient staffing, accident hazards and housekeeping and maintenance of facility. This deficient practice had the potential to affect 28 of 28 residents residing in the building.</p> <p>Findings include:</p> <p>During an interview with the administrator on 1/26/2012 at 1:45</p>	F0520	Regarding F520, the facility respectfully requests the opportunity for paper review of this tag. This is based on the facility's judgment that we did identify issues noted within the citation in our Quality Assurance meetings which are held on a monthly basis. It is the policy of Miller's Merry Manor that the facility maintain a quality assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. 1. The facility currently does have a quality assurance committee in	02/26/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992		
(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>p.m., she indicated the facility department heads have monthly concern logs that are filled out. They then fill out the plan of action. The Quality Assurance (QAA) team will then put the action plan in place and a person will be designated for follow-up.</p> <p>The administrator indicated the Maintenance Director had noted a QAA concern on January 12, 2012, that the corner guards needed applied to the walls for rough edges. She indicated the corner guards were not replaced until this concern was brought to their attention on 1/24/2012. She indicated the facility was waiting for quotes for the materials.</p> <p>She indicated the housekeeping supervisor had not identified the vents as a concern.</p> <p>She indicated call light times were addressed in July of 2012 and had not been identified as a QAA concern since that time.</p> <p>She indicated she was not aware of a concern with when the residents were being awakened in the a.m.</p> <p>3.1-52(b)(2)</p>		<p>place. The quality assurance committee does meet monthly to identify and implement a plan of action for the identified areas of concerns such as resident choices, sufficient staffing, accident hazards, and housekeeping and maintenance of facility. 2. All residents have the potential to be affected by the same practice. All department managers have specific audit tools to be completed according to the QA calendar of events. All department heads or designee will complete their required audits monthly.3. Department heads will be re-in-serviced on the policy and procedure of the Quality Assurance committee. (See attachment P)4. Any concerns identified by the QA audits will be documented on a concern form and addressed immediately by the appropriate department head. (Attachment C) All QA audit concerns will be brought to the monthly QA meeting and concerns will be logged on the Quality assurance improvement summary log (Attachment D). This will reviewed in QA meeting monthly until the issues are resolved. Department heads also complete monthly QA Calls Scripts in order to identify specific resident concerns. These are also reviewed at the monthly QA meeting.5. All systemic changes and inservices will be completed by February 26, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
--	--

(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