

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00141207.</p> <p>Complaint IN00141207-Substantiated. Federal/State deficiencies related to the allegations are cited at F 246, F 282, F328, and F465.</p> <p>Unrelated deficiencies are cite.</p> <p>Survey dates: December 15, 16, and 17, 2013.</p> <p>Facility number: 000018 Provider number: 155053 AIM number:100273930</p> <p>Survey team: Janelyn Kulik, RN, TC Brenda Buroker, RN William Greeney, Gereralist</p> <p>Census bed type: SNF: 9 SNF/NF: 50 Residential: 21 Total: 80</p> <p>Census payor type: Medicare: 7 Medicaid: 51 Other: 22</p>	F000000		
---------	--	---------	--	--

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: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>Total: 80</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on December 26, 2013, by Brenda Meredith, R.N.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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	
F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record review, the facility failed to provide privacy during personal care for two of two residents observed (Residents #F and #T) and one of six residents reviewed during medication pass. (Resident #K)</p>	F000164	Residents # F, #K and #T were provided necessary care without mention of concern. 100% audit completed 12.31.13 to ensure privacy was provided for all residents receiving care. No other residents were noted to be affected by this deficient practice. A sample of 10 residents will be observed on all shifts daily x 1	12/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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>Findings include:</p> <p>1. On 12/15/13 at 8:27 a.m., observation of C.N.A.s #1 and #2 providing incontinent care for Resident #F indicated the resident's clothing was saturated with liquid stool. The residents slacks and underwear were removed and care was provided. The C.N.A.'s left the resident exposed from the waist down as they cleaned her up and obtained bed clothing. They did not cover the resident's lower legs in order to only leave the resident's necessary body exposed.</p> <p>2. On 12/15/13 at 9:51 p.m., Resident #T was observed being undressed by C.N.A. #2 and L.P.N. #1 while he was sitting on the toilet. He was left naked sitting on the toilet while one of the staff left the room to get a gown. There was no attempt to cover the resident while he was sitting on the toilet.</p> <p>Review of the Pericare Policy provided by the DoN at 11:50 a.m. on 12/17/13, indicated... "Explain procedure to resident and provide privacy. "</p> <p>3. During an observation of a medication pass on 12/16/13 at 9:07</p>		<p>week, weekly x 4 weeks and monthly x 6 months. Nursing staff re-educated 12.20.13 on Policy and Procedure for Peri Care (Attachment #1), and resident rights regarding privacy with care (Attachment #2). A minimum of 10 residents per unit will be observed to ensure privacy is provided during care. Corrective action will be QA monitored using the Resident Privacy Audit Tool. (Attachment #3). This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure residents are provided privacy with care. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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.m., L.P.N. #2 provided a mouth treatment to Resident #K as he sat in the lounge across from the nurses' station. The resident resisted a little by moaning and the nurse stated, "He hates this." A female resident in the lounge watched as the care was provided.</p> <p>3.1-3(p)(2) 3.1-3(p)(4)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview the facility failed to ensure call lights were positioned in reach of the residents for 2 of 8 residents observed for call lights in a sample of 19. (Residents #D and #J)</p> <p>Findings include:</p> <p>1. On 12/15/13 at 9:31 p.m., Resident #D was observed laying in bed on her left side sleeping. Her call light was attached to the top of the head board of the bed on the left side above the resident's head.</p> <p>On 12/17/13 at 7:05 a.m., Resident #D was observed laying in bed on her left side sleeping. Her call light was attached to her recliner and not within reach of the resident.</p> <p>On 12/17/13 at 9:31 a.m., Resident #D was laying in bed on her left side sleeping. Her call light was attached to her recliner and not within reach of the resident.</p>	F000246	Resident #D is up ad lib and is able to access her call light in any location, however , this resident does not use her call light related to the diagnosis of mild intellectual disabilities and senile dementia. Resident #D's care plan reflects this. Resident # J does not use the call light and is unaware of its purpose due to her poor cognition related to diagnosis of senile dementia. Resident #J's care plan reflects this. 100% audit completed 12.31.13 on all residents to determine that all residents had call lights within reach. No other residents were affected by this deficient practice. All residents will be monitored daily at various times to ensure call lights are within reach on all shifts. Nursing staff were re-educated on 12.20.13 on the Policy and Procedure Call Light Procedure. (Attachment #4). Department Heads to complete daily observations of call light placement to ensure all residents that are appropriate for call light usage have them within reach at all times. Corrective action will be QA monitored using the Action	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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 record for Resident #D was reviewed on 12/16/13 at 11:00 a.m. The resident's diagnoses, included but were not limited to, dementia, diabetes mellitus, osteoarthritis, and anxiety.</p> <p>The Annual Minimum Data Set Assessment (MDS) dated 10/19/11 indicated, the resident was understood and understands. She had a BIMS (Brief Interview of Mental Status) of 7 which indicated she was severely cognitively impaired.</p> <p>A care plan with a focus of Falls, dated 10/16/13, indicated the interventions, included but were not limited to, the call light to be in reach.</p> <p>Interview with the DoN (Director of Nursing) on 12/17/13 at 9:35 a.m., indicated call lights should be in reach of the residents. She further indicated Resident #D could get to her call light if it was attached to the head of her bed.</p> <p>2. On 12/15/13 at 9:45 p.m., Resident #J was observed laying in bed on her left side sleeping. Her call light was observed laying on the floor under the foot of the bed.</p>		<p>Rounds Audit Tool. (Attachment #5). This QA tool will be used by the DON or Department heads daily x 3 months, then daily indefinitely to ensure residents that are deemed appropriate for having the ability to use a call light will have a call light in reach at all times. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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>On 12/15/13 at 10:00 p.m., 10:16 p.m. and at 10:35 p.m., Resident #J was observed laying in bed on her left side sleeping. Her call light was observed laying on the floor under the foot of the bed.</p> <p>The resident's record was reviewed on 12/16/13 at 10:00 a.m. Her diagnoses, included but were not limited to, dementia, diabetes mellitus, chronic obstructive pulmonary disease, anxiety, anemia, and osteoarthritis.</p> <p>The Annual Minimum Data Set Assessment (MDS), dated 9/18/13, indicated the resident was usually understood and sometimes understands. She had problems with long and short term memory.</p> <p>Interview with the Director of Nursing (DoN) on 12/17/13 at 9:35 a.m., indicated it was not good if the call light had been on the floor at the end of the residents bed.</p> <p>The Call Light Procedure policy was provided by the DON on 12/17/13 at 11:44 a.m. The purpose indicated, "To allow Resident to request assistance when needed." The procedure, included but was not limited to, "Place call light within</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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	
	reach of resident at all times." This Federal tag relates to complaint IN00141207. 3.1-3(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 and interview, the facility failed to ensure the resident's care plans was followed for 1 of 8 residents reviewed for care plans in a sample of 19. (Resident #B)</p> <p>Findings include:</p> <p>The record for resident #B was reviewed on 12/16/13 at 2:13 p.m. The residents diagnoses, included but were not limited to, anoxic brain damage, pneumonia, anxiety, depression, and quadriplegia.</p> <p>The Quarterly Minimum Data Set Assessment, dated 11/20/13, indicated the resident was rarely to never understood and usually understands. Her BIMS (Brief Interview of Mental Status) was an 11 which indicated she was moderately cognitively impaired.</p> <p>A 11/19/13 physician order indicated the resident was to receive Ativan (anti-anxiety medication) 1 mg (milligram) twice a day as needed for</p>	F000282	<p>No negative effects noted to resident #B from receiving Ativan per Physician's order. When seizure or seizure like activity occurs, resident #B to be assessed per her plan of care and seizure assessment (if applicable) to be documented in the residents clinical record.</p> <p>Please note Resident #B no longer receives Ativan prn for seizures per Physician order received 12.31.13 (Attachment #19). 100% of residents with seizure diagnosis audited on 12/31/13- no other residents have orders for ativan for seizures. No other residents were affected by this deficient practice. Nursing staff re-educated on 12.20.13 on utilizing the Nursing Seizure Assessment (Attachment #6) in the electronic medical record and on the Policy and Procedure for Care Plan Development and Review Sect. CI-IX. (Attachment #7). A minimum of 10 residents care plans per unit will be reviewed to ensure care plans are updated, followed, and any assessments indicated will be completed per plan of care. Corrective action will be QA monitored using the Care Plan Review Audit Tool. (Attachment</p>	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>seizure like activity.</p> <p>Review of the Medication Administration Record (MAR) for December, 2013, indicated the resident received the as needed Ativan one time on December 1, 2, 3, 4, 7, and 14. Review of the documentation on the reverse side of the MAR indicated Ativan was given on 12/7/13 at 6:30 p.m. for seizure activity and it was helpful at 7:30 p.m. The Ativan was given on 12/13/13 at 3:00 a.m. for seizure activity and was helpful. The Ativan was given on 12/14/13 at 4:00 p.m. for seizure activity and was helpful at 5:00 p.m. There was no other documentation in regards to the resident receiving the Ativan on the MAR.</p> <p>A care plan initiated on 12/6/12, and revised on 11/7/13, indicated, a focus of the resident has a seizure disorder. The interventions included but were not limited to, record characteristics of seizures/tremors such as onset, duration and body movements and administer medications as ordered.</p> <p>Review of the progress notes, from 12/1/13 to 12/17/13, did not indicated the resident had any seizure like activity.</p>		<p>#8). This QA tool will be used by the DON or designee weekly x 4 weeks, then monthly x 6 months to ensure care plans are being followed and all correlating assessments are completed. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13We respectfully request an Informal Dispute regarding F 282-SS-D-Services provided by qualified persons per care plan. This was cited on 2567 dated 12/17/13. We request this tag be deleted and will explain why this citation we not deserved and rationale not valid. Resident B's care plan was carried out in regards to administering Ativan for seizure like activity. Upon investigation of nursing staff not documenting actual observation of seizure like activity it was discovered that the reason was because they did not actually observe the seizure activity, but were giving the medication per demands of resident B's husband. It is reported by nursing staff that the resident's husband would report to the nurses that resident B was "twitching" and needed her Ativan. However, after the nursing staff completed an assessment, there was no seizure activity observed by nursing staff. The Dr. had recently changed the Ativan order to prn seizure like activity in an effort to reduce the anxiolytic</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>Interview with the Director of Nursing on 12/17/13 at 11:50 a.m., indicated she had not other information in regards to the administration of the Ativan medication.</p> <p>This Federal tag relates to complaint IN00141207.</p> <p>3.1-35(g)(2)</p>		<p>expecting to have minimal seizure activity therefore it would not be given. While the facility continues to address concerns and issues with resident B's husband we also have maintained providing excellent care, assessment and addressing of her needs. Resident B is on anticonvulsant medication-Keppra. This medication has been successful in controlling resident's seizures for several years. She does get Keppra levels and the most recent one was 12/27/13. The resident also has a baclofen pump to manage spasms and twitching. With this being said, the reasoning for the Ativan was changed to prn anxiety in effort to more appropriately treat the conditions and adjusting the anticonvulsant medications to manage any seizure activity. Please note also that it has been recommended and requested that the resident receive an antidepressant which may help the anxiety which may contribute to the "seizure-like activity" however, the husband refuses the medication despite education of the benefits and the lack of interaction with other medications as well as it not being contraindicated in a TBI (traumatic brain injury). In conclusion, the nursing staff, under the direction of the D.O.N., recommendation of the consultant pharmacist, physician orders and standards of practice</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>this resident is having her services provided by qualified persons/per care plan. There were not any negative outcomes to resident B. She has improved dramatically under the care of the nursing staff throughout her stay as evidenced by Resident B's change in BIM's score-score of 99 upon admission, resident B's last score on 11-20-13 was 10. Upon admission resident was comatose without verbal or nonverbal response, resident B is now able to communicate using sign language, facial movements and gestures. Resident B also displays appropriate emotional responses and is able to make wants and needs known, for example- she is able to alert staff of the need for incontinent care, medications and suctioning needs. She is also able to manipulate a television remote control, call light and cell phone, all tasks that she was unable to complete upon admission. Resident has also exhibited a decrease in respiratory infections, urinary tract infections, skin issues, and an overall improvement in medical stability. We will be glad to provide any supportive documents as needed to further validate this dispute.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the transport lift was not used when it was identified by staff as broken. This had the potential to affect eight residents on one of two wings of the facility who needed the lift for transfers. (Residents #F, E, K, O, P, Q, R, S)</p> <p>Finding includes:</p> <p>1. On 12/15/13 at 8:27 p.m., Resident #F was observed being transferred with a transport lift (a mechanical portable device used to place a resident in a sling and move from one area to another) from her wheelchair to bed using a lift by C.N.A.s #1 and #2. Once the resident was up in the lift and suspended in the air the base legs of the lift moved. C.N.A. # 1 stated the lock would not stay in place and the legs move. By the time the lift was placed at the resident's bed, the two lift base legs were parallel with each other.</p>	F000323	<p>The mechanical lift in question was immediately removed from the wing and placed out of service and was not to be used on any resident until repaired. No residents were affected by this deficient practice. Nursing staff were re-educated on 12.20.13 on the Policy and Procedure Mechanic Lift Transfers (Attachment #9) and on the importance of immediate removal of an improperly working mechanical lift. Random checks for lift function to be completed to ensure all lifts being used are functioning properly. Corrective action will be QA monitored using the Lift Function Audit Tool (Attachment # 10) . This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure all lifts being used for resident transfers are functioning properly. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13</p>	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>Following the care, the C.N.A. was interviewed regarding the lift not functioning properly. She stated the lift was noticed to not lock properly the previous day. She had not reported the malfunctioning lift to any supervisory staff.</p> <p>Interview with L.P.N. #1 on the unit, on 12/15/13 at 8:41 p.m., indicated the nurse was not aware the lift did not lock.</p> <p>The ADON and Administrator were informed, on 12/15/13 at 8:45 p.m., of the malfunctioning lift. The Administrator indicated the lift would be taken out of service.</p> <p>On 12/15/13 at 10:25 p.m., the DoN provided a list of residents that were transferred by the transfer lift. The list included the following residents: Residents #E, #K, #O, #P, #Q, #R, and #S.</p> <p>Review of the lift manufacturer's user manual provided by the DoN at 10:25 p.m. on 12/15/13 indicated, "The legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately."</p> <p>3.1-45(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a resident was suctioned in a timely manner for 1 of 2 residents reviewed who required suctioning in an sample of 19. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 12/16/13 at 2:13 p.m. The resident's diagnoses included, but were not limited to, anoxic brain damage, anxiety, depression, and quadriplegia.</p> <p>Review of the Medication Administration Record (MAR) dated November 2, 2013, indicated to suction frequently, notify MD (Medical Doctor) if increased temp (temperature) or decreased sats (oxygen saturation), and trache (tracheostomy) deep suction as</p>	F000328	Resident #B exhibits no signs of untimely suctioning as evidenced by increased temperature, decreased oxygen saturations, respiratory distress and/ or respiratory infection. 100% audit completed and as of 12/31/13 no other residents residing in the facility require suctioning. No other residents were affected by this deficient practice. Nursing staff were re-educated on 12.20.13 on the Policy and Procedure for Suction Procedures (Oral, Oropharynx, Nasopharynx and Endotracheal) (Attachment #11). Nursing to complete every 2 hour checks on resident respiratory status, suctioning needs and overall care needs and documentation to be completed by Nursing staff responsible for resident #B's care. These checks will be completed on a daily basis. Corrective action will be QA monitored using the Suctioning Audit Tool (Attachment #12). This QA tool will be used by the	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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>needed [use 14 FR (French) cath (catheter)].</p> <p>In a confidential interview, on 12/15/13 at 8:30 p.m., it was indicated, the resident has to wait over an hour for the nurse to come and attend the resident after she has turned on her call light to be suctioned.</p> <p>In a confidential interview, on 12/16/13 at 9:10 a.m., it was indicated staff have to ask the nurse five to six times before they will go into Resident #B's room to suction her after she has put on the call light.</p> <p>In a confidential phone interview, on 12/16/13 at 11:20 p.m., it was indicated, Resident #B sometimes has to wait up to one and a half hours to get suctioned after requesting to be suctioned. It was further indicated the nurses were informed several times of the resident's request before the nurse will come to the residents room to attend to the resident.</p> <p>In a confidential interview, on 12/17/13 at 7:10 a.m., it was indicated, Resident #B sometimes has to wait thirty minutes for the nurse to come to her room after she has turned on her call light to be</p>		<p>DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure resident suctioning needs are met in a timely manner and residents respiratory status remains stable. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13 We respectfully request an Informal Dispute regarding F 328-SS-D Treatment for Special Needs. This was cited on 2567 dated 12/17/13. We request this tag be deleted and will explain why this citation we not deserved and rationale not valid. The citation says that "confidential interviews" were conducted to determine the basis of this citation. The surveyors did not at any single time during the 3 day survey make an observation to support that resident B was not suctioned timely or appropriately. The resident did not report or complain of this occurrence. At the time of the exit with surveyors on 12/17/13 the facility DON, Administrator and Quality Assurance nurse questioned surveyor # 1 as to who was interviewed. Surveyor #1 was directly questioned "were the confidential interviews done with C.N.A.'s?" Surveyor replied "Yes they were". When questioned the surveyor how a C.N.A. could be expected to determine if the resident needed suctioning, or if in fact the nurse did or did not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>suctioned.</p> <p>In a confidential interview, on 12/17/13 at 7:15 a.m., it was indicated, Resident #B has to wait an hour or longer after putting on her light to be suctioned for a nurse to attend to her. It was further indicated, staff sometime go to the nurse 10 times before the nurse will attend to the resident.</p> <p>In a confidential interview, on 12/17/13 at 7:20 a.m., it was indicated, Resident #B sometimes waits one to one and a half hours for the nurse to suction her after she requests to be suctioned.</p> <p>Interview with the Resident # B, on 12/17/13 at 7:25 a.m., indicated she waited three hours to be suction last night. The resident communicated this by using sign language. This information was confirmed by the resident's husband.</p> <p>This Federal tag relates to complaint IN00141207.</p> <p>3.1-47(a)(5)</p>		<p>suction the resident based on assessment. It was also explained that a C.N.A. would not be able to observe directly if the nurse went into resident room, answered call light, and left only to have resident ring call light again. It was not made known how the questions were posed to the C.N.A.'s. It was not taken into consideration that it is out of their scope of practice to determine if resident had been suctioned or the need to be suctioned. We conducted interviews with C.N.A.s that care for resident B and came to a different conclusion as will be explained. Most importantly the nursing staff did not violate the Regulation F 328 483.25 (k)(4) standard of tracheal suctioning. The procedures and probes as listed in this section were not noted, found or warranted which makes it very clear this was not a violation of this tag as stated below: 1) Do the residents have signs of an obstructed airway or need for suctioning (e.g., secretions draining from the mouth or tracheostomy; unable to cough to clear chest; audible crackles or wheezes; dyspneic, restless or agitated)? Resident B had none of these problems. Her oxygen saturations were 90% or greater as documented on medical record and observed by surveyors. Resident B has also had chest X-rays the past 4 months consecutively which are</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>clear (these too were presented to the surveyor #1). The resident has been free of respiratory infections. Resident B is able to effectively cough up most of her secretions as this in her best interest and per encouragement as stated on the plan of care. 4 C.N.A's and 4 licensed nursing staff that provide care for resident B were interviewed by D.O.N. and Quality Assurance nurse on 12/30/2013. The following are some of the responses when questioned as to the response time to suctioning needs of resident B and situations about call light. We were told by 3 of the C.N.A's that they were the ones interviewed by surveyors too. C.N.A. # 1) "Yes resident B rings her call light frequently and will request the same list of things repeatedly whether they are valid or not and even if they had just been performed. These include "being wet, being hot, being cold, wanting suctioned, wanting meds." I answer her call light sometimes 30 times a shift. She will say she wants suctioned and I will report it to the nurse then I will go about my other work and her call light will be on again and she will request the same thing and I will tell the nurse again. When questioned if she was aware of whether the nurse had been in resident B's room or not (did not expect them to try to determine if the resident needs suctioned or not as it is not within their scope</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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	
			of practice) the response was that she couldn't say for sure as she went on about her work being in and out of other residents rooms or showers. When questioned if the nurse provided an explanation to aide request the answer was "no, I just tell them and go on" Plus her (resident B) husband puts us (C.N.A.'s) in the middle things wanting us to say if nurse has been in or not. It is very frustrating and hard to work with this kind of pressure from him. C.N.A #2) Similar responses as above. When questioned if she factually knows how long it is between times of suctioning or if a nurse has been in and out of the residents room the response is the same " I can't actually say because I have gone and taken care of my other residents" " I do know that I can be in there and change her and do care and ask if she needs anything else and walk out of the room and she will immediately put her call light on and ask for the same care say she is wet when I just changed her and when I tell her that I did then she will go down her mental list that her husband has trained her on and ask for all of them e.g. too hot, too cold, want suctioned, want meds." When questioned if she felt like resident B's needs got met she said 'oh yes, we are in there all the time' C.N.A. #3) Says "she has never been aware of nurse not responding to request to suction or check on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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 and responses have been very quick". C.N.A. #4) Says "I thought it may have been up to 30 minutes for the nurse to go suction the resident after I told her. Again questioned if she sat and timed or could factually say this was true? She was unable to say she had and again it is not within her scope of practice to know if resident had been assessed and determined not to need to be suctioned. L.P.N.# 1) "I have always gone and assessed or suctioned resident when requested it or needed" When explained that C.N.A. says it could be up to 3 hours for a response to resident wanting suctioned the nurse was insulted and said " the aides are in other resident rooms or giving showers and do not see me go into the room and there are times when I explain to resident that she does not need suctioned based upon my assessment and I don't feel comfortable suctioning her unnecessarily. Also you can go in there and suction her, walk out and within 5 minutes she will want suctioned again. We all answer her call light and take care of her." L.P.N. # 2) When questioned if she was aware of resident B ever going 30 minutes to 3 hours without being assessed when requested to be suctioned or want meds. The nurse says "I have never done that or seen that done. A lot of times her husband will ring her		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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
			light as soon as he comes in just to get us in there, and say she wants suctioned even if she doesn't need it or we had just been in there." L.P.N. #3 is supervisor of the other nurses and says "I personally have never observed any of the nurses not responding to resident's (B) needs." R.N. #4 has been in facility many times at all hours of day and night and has observed resident B's call light ring repeatedly up to 10-15 times an hour and someone has always responded and "I have personally gone down to check on resident and she is not in any distress, no outward signs of needing suctioned." Again let us reiterate that this resident has no negative outcomes, no indication that tracheostomy care including suctioning is not being performed. The physician documents that respiratory status is stable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 observation, interview and record review, the facility failed to</p>	F000441	No residents are noted to be exhibiting any negative outcomes	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>ensure direct care staff followed hand washing procedures during six care observations on 1 of 2 units.</p> <p>Findings include:</p> <p>1. During an observation on 12/15/13 at 8:16 a.m., C.N.A. #1 and C.N.A. #2 provided pericare for Resident #F. The resident had a large liquid brown bowel movement in the brief which dripped out of the brief as the resident was transferred. Both C.N.A.'s wore gloves as they turned the resident side to side and cleansed the stool from the resident's skin. Following the care, C.N.A. #2 with the same gloved hands, opened the resident's bedside drawer and removed lotion to apply to the resident. The same C.N.A. placed the lotion back into the drawer, then removed gloves and without washing hands opened the door and left the room and went down the hall.</p> <p>C.N.A. #1 did not remove her gloves and touched numerous items in the room; the bed rails, the bed controls, soap, over bed light chain, bathroom door knob, and wheelchair. The C.N.A. removed her gloves and without washing her hands, touched the drawer in the resident's room and the lift as she pushed it into the hall.</p>		<p>from these practices. LPN # 1 was re-educated 1:1 regarding the Policy and Procedure for cleaning of the glucometers. Audits and observation will be completed on all shifts. No other residents were affected by this deficient practice. Nursing staff re-educated 12.20.13 on the Policy and Procedures for Hand Washing and Hand Asepsis (Attachment #13), Use of Medical Gloves (Attachment #14), Oral Care (Attachment #15), Cleaning of Glucometer (Attachment #16), Injections-(Subcutaneous (Attachment #17), Intramuscular and Intradermal) . Skills check offs on hand washing, proper glove use, resident privacy, injections and cleaning of glucometers to be completed. Corrective action will be QA monitored using the Infection Control Audit Tool (Attachment #18) . This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure hand washing is performed accurately, gloves are used per policy, residents are provided privacy with care, and glucometers are cleaned per policy. Skills check offs to be completed annually and as needed. The results will be reviewed by the QA committee and any recommendations will be implemented. Date of completion 12.31.13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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>2. During an observation of a glucometer check for Resident #E on 12/15/13 at 8:49 p.m., L.P.N. #3 removed her gloves and used the resident's bathroom and washed her hands for six seconds, turned off the water with her bare hands and then dried her hands.</p> <p>Following the use of glucometer for the blood sampling for the resident at 9:01 p.m., the glucometer was placed back into the case without cleaning it. Interview with L.P.N. #1 at the time indicated she should have cleaning it with alcohol after resident use. Interview with the D.O.N. at the time indicated the facility used a wipe to disinfect glucometers and showed the wipe was present in the locked medication cart. The D.O.N. indicated the glucometer was to be left wet for two minutes.</p> <p>3. During an observation on 12/16/13 at 9:07 a.m., L.P.N. #2 provided a mouth swab treatment to Resident #K. The L.P.N. wore gloves to provide the mouth care, removed the gloves and without washing her hands or use of hand sanitizer, picked up a container of yogurt from the medication cart, got keys out of her pocket and opened the door to the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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 room in the nurses station, put the yogurt in the refrigerator and then went into the bathroom.</p> <p>4. Observation on 12/16/13 at 11 a.m. of a breathing treatment for Resident #L, L.P.N. #2 wore gloves as she provided the nebulizer treatment. She touched the equipment and hands of the resident as the resident received the treatment for 20 minutes. She used the same gloved hands to place the call light next to the resident, removed her gloves and with out washing her hands turned the call light on for the resident's roommate.</p> <p>5. During an observation on 12/16/13 at 11:32 a.m. L.P.N. #3 performed a finger stick for glucometer testing for Resident #M. The L.P.N. wore gloves to obtain the blood sample, left the resident room carrying the glucometer and lancet, went to the medication cart at the nurses station, disposed of the lancet and got keys out of her pocket to open the medication cart and get the wipe to cleanse the glucometer, pushed the buttons for the security pad on the clean utility door and then washed her hands.</p> <p>6. During an observation on 12/17/13 at 8:05 p.m., L.P.N. #4 gave two</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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>insulin injections to Resident #N. The L.P.N. did not wear gloves while giving the injections. She wiped the resident's skin with an alcohol prep before and after the injections with her bare hands. She left the room without washing her hands and touched the door knob to the resident's room, went to the medication cart used her pen to sign off the drugs and got keys from her pocket to open the medication cart. Interview with L.P.N. #4 at the time regarding whether they were to wear gloves when giving injections indicated she did not know.</p> <p>Review of the facility policy provided by the DoN at 8:43 a.m. on 12/17/13, the procedure regarding Hand Washing and Hand Asepsis included: "A. Prepare paper toweling. B. Turn on water; adjust temperature to a comfortable temperature. C. Apply soap to hands from the dispenser. D. Angle arms down holding hands lower than elbows. Wet hands and wrists. Rub vigorously for at least 20 seconds. (Lace your fingers together to wash in between them.) E. Clean nails by rubbing them in palm of other hand. F. Rinse hands thoroughly, keeping them downward, allow the water to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>run from the wrist to the fingers. G. Pat hands dry with paper towel. H. Turn off faucets with paper towel and discard towel immediately in waste receptacle."</p> <p>The policy regarding Use of Medical Gloves (application and removal) indicated:</p> <p>"RATIONALE: A. Medical gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident care procedures where contact may involve touching a residents mucous membrane and non-intact skin, secretions, excretions, blood or body fluids. B. Gloves are worn to reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite (any substance that absorbed and transmits infectious material) can transmit these microorganisms to another resident. C. Gloves should not be used as a substitute for hand-washing. D. Gloves should be used for hand contaminating activities, handling soiled linen, when touching blood, body fluids, secretions, excretions,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>mucous membranes and non intact skin.</p> <p>GUIDELINES:</p> <p>A. Hands should be washed initially prior to putting on the gloves.</p> <p>B. Nails should be short enough to not tear the gloves.</p> <p>C. Medical gloves are designed for "single use" only and should not be washed, reprocessed, or decontaminated.</p> <p>D. Gloves should be removed and hands washed with soap and water immediately after glove removal. (Hand washing with soap and water is highly recommended when gloves are removed because of a tear or puncture and the HCW has had contact with blood or another body fluid, hand rub with alcohol gel may be used only if soap and water is not available upon removal of gloves.)</p> <p>E. Gloves should be removed and hands washed between care activities with patients.</p> <p>F. Gloves should be removed and hands washed when the integrity of the gloves is in doubt.</p> <p>G. As a general policy, health-care settings should preferably select non-powdered gloves for use to prevent skin reactions to HCW's hands.</p> <p>H. Gloves may need to be changed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>during the care of a single patient.</p> <p>GLOVE REMOVAL AND DISPOSAL PROCEDURE:</p> <p>A. Pinch one glove at the wrist level to remove it, without touching the skin of the forearm, and peel away from the hand, thus allowing the glove to turn inside out. Hold the removed glove in the gloved hand and slide the fingers of the ungloved hand inside between the glove and the wrist. Remove the second glove by rolling it down the hand and fold into the first glove. Discard the removed gloves into the trash receptacle inside the patients room as necessary.</p> <p>B. Wash hands thoroughly.</p> <p>C. Dispose of waste as per policy. "</p> <p>The facility policy regarding glucometer use, proved by the Administrator at 11:44 a.m. on 12/17/13 indicated:</p> <p>"PURPOSE: To maintain infection control between resident use.</p> <p>PROCEDURE:</p> <p>A. The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe (Clorox, Lysol, Gulf South etc) and completely wiping down the glucometer so it is visibly wet. Avoid</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>getting the screen wet, as the disinfectant could leak into the internal components and destroy the meter.</p> <p>B. Disinfectant should never be sprayed directly on the machine. Always use a cloth or wipes.</p> <p>C. Follow manufacturer's instructions related to length of time to disinfect before reusing. Air dry time is typically around 30 seconds, so you must rewet the meter or wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the manufacturer.</p> <p>D. Place wrapped Glucometer in covered container and set timer for manufacturer's contact kill time.</p> <p>E. Once contact kill time has expired, wait and allow to air dry before re-using the glucometer."</p> <p>7. On 12/15/13 at 9:50 a.m. CNA #1 was observed taking a bag of soiled items into the soiled utility room. She unlocked the door and stepped inside and left the bag containing the soiled items. The door to the soiled utility room never closed all of the way. She walked out of the soiled utility room indicating she need to wash her hands. She then unlocked the clean utility room door and went inside and washed her hands.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
--	---

(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>On 12/16/13 at 1:46 p.m. Housekeeper #1 unlocked the soiled utility room. She indicated at this time the sink in the soiled utility room works but the water pressure was low.</p> <p>An interview on 12/17/13 at 11:15 a.m. with the ADoN (Assistant Director of Nursing), indicated she was in charge of infection control. She indicated she has a monthly log when she documents the type of infection, location within the facility and if the resident was on any antibiotics. She uses this to see if she needs to do additional teaching. She further indicated staff are in-serviced when the are hired and throughout the year. She had not had any issues with infections control and the late in-service was on September 6, 2013.</p> <p>3.1-18(a) 3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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			
F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure the resident's environment was comfortable to live in related to malodorous smells in the lobby and outside of a resident's room for one of one lobby and one of two units. (Resident #U)</p> <p>Finding include:</p> <p>On 12/15/13 at 8:02 p.m. upon entering the facility a malodorous smell was observed in the lobby of the facility. There were no residents in the lobby area at this time.</p> <p>On 12/15/13 at 8:36 a strong urine smell was observed outside of the room of Resident #U. At this time Resident #U was observed to be sitting in his recliner. He was wearing light gray sweat pants. There was a wet mark noted on his sweat pants at the crotch and going down the left leg. There was a strong urine smell in the resident's room. The resident indicated at this time he did not need anything and everything was fine.</p>	F000465	<p>An ionizer machine was placed in the front lobby of the facility behind the front desk. Resident #U was changed and provided peri care. Resident #U was placed on a toileting plan and is to be checked every 2 hours and prn. No other residents were affected by this deficient practice. Nursing staff was re-educated on 12.20.13 on the Policy and Procedure for Peri Care (Attachment #1). Nursing staff to monitor resident #U for needs including incontinent care per the 2 hour and prn plan of care. Nursing staff to monitor a sample of a minimum of 10 incontinent residents to ensure incontinent care provided in a timely manner. A sample of a minimum of 10 residents will be assessed for concerns of malodorous scents daily over all shifts. Any episodes of malodorous smells will be investigated by nursing and/or housekeeping with the appropriate solution to eliminate the odor to follow. Corrective action will be QA monitored using the Action Rounds Audit Tool (Attachment #5). This QA tool will be used by the DON or designee daily x 1 week, weekly x 4 weeks, then monthly x 6 months to ensure resident #U</p>	12/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173			
(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 list of interview residents provided by the DoN (Director of Nursing) was reviewed on 12/17/13 at 1:00 p.m. The list indicated Resident #U as interviewable.</p> <p>Review of a Concern Record form provided by the Social Service Director on 12/17/13 and review on 12/17/13 at 11:30 a.m. indicated, on 12/13/13 at 10:00 a.m., it was reported Resident #U had been soaked in urine and BM (bowel movement) the past three mornings. When checking him this morning his sheets, pad, brief were saturated. There was urine drying on the pad and the room smelled of urine. He voiced that nursing had not checked him yet this morning. The action taken was that it was brought to the Unit Managers attention and the resident was changed. Social Service will be checking with the resident everyday. The resolution indicate the resident reported on issues and will continue to follow up.</p> <p>On 12/16/13 at 8: 13 a.m. upon entering the facility a malodorous smell was observed in the lobby of the facility. There were residents observed in the dining room across form the lobby.</p>		<p>and a random sample of incontinent residents are provided timely peri care with each incontinent episode and all malodorous scents will be addressed accordingly. The results will be reviewed by the QA committee and any recommendations will be implemented.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173		
(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>On 12/17/13 at 6: 45 a.m., upon entering the facility a malodorous smell was observed in the lobby of the facility. There were no residents observed in the area at this time.</p> <p>This Federal tag relates to complaint IN00141207.</p> <p>3.1-19(f)</p>				