

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2013
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 524 ANDERSON RD CHESTERFIELD, IN 46017
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F000000	<p>This visit was for Investigation of Complaint IN00129644.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00129644 - Substantiated. Federal/State deficiencies related to the allegation are cited at F323 and F463.</p> <p>Survey Dates: May 28, 29, 30, and 31, 2013.</p> <p>Facility Number: 00524 Provider Number: 155617 AIM Number: 100267090</p> <p>Survey Team: Karen Lewis, RN, TC Ginger McNamee, RN Tina Smith-Staats, RN Karen Koeberlein, RN</p> <p>Census Bed Type: SNF: 2 SNF/NF: 51 Total: 53</p> <p>Census Payor Type: Medicare: 6 Medicaid: 34</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.

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	<p>Other: 13 Total: 53</p> <p>Sample 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN.</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview the facility failed to ensure a cognitively impaired resident was supervised in the dining room to prevent a fall for 1 of 4 residents reviewed for falls and accidents. (Resident #'s B, C, D, and E)</p> <p>Findings include:</p> <p>1.) Resident #C and Resident #D were observed sitting in the Dining Room from 11:01 a.m. to 11:20 a.m. on 5/30/13. There were no staff present during the observation.</p> <p>2.) Resident #C's clinical record was reviewed on 5/30/13 at 9:00 a.m. The resident had a 3/6/13 quarterly MDS (Minimum Data Set) assessment. The assessment indicated Resident #C had a BIMS (Brief Interview for Mental Status) of 3 indicating the resident had severe cognitive impairment.</p> <p>3.) Resident #D's clinical record was</p>	F000323	<p>Miller's Merry Manor respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation.</p> <p>1. Residents will not be in the dining room unsupervised unless it is determined through the resident's care plan that resident is appropriate to be left alone in the dining room.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. Facility will add a video camera to the dining room, which can be viewed at the nurse's station. The dining room doors will be closed until a half hour before meal service. All staff will be in-serviced on the importance of making sure cognitively impaired residents are not left unattended in the dining room.</p> <p>4. Nurse, or designee, will complete the Dining Room Supervision Audit (Attachment C) daily x30 days, weekly x 1 month, and then monthly thereafter.</p>	06/30/2013			

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	<p>reviewed on 5/31/13 at 1:10 p.m. The resident had a 3/15/13 significant change MDS assessment. The assessment indicated Resident #D had a BIMS of 5 indicating the resident had severe cognitive impairment.</p> <p>4.) The clinical record for Resident #B was reviewed on 5/30/13 at 3:53 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia, hypertension, anxiety, and diabetes.</p> <p>A quarterly Minimum Data Set Assessment, dated 1/28/13, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The score indicated Resident #B had severe cognitive impairment.</p> <p>An initial occurrence assessment dated 4/13/13, indicated Resident #B was in the dining room and stood up. Resident #B was pulling at the table cloth and fell. Another resident in the dining room went to the kitchen door and knocked. The kitchen staff called for the nursing staff. The nurse found Resident #B lying on the floor with a large laceration to the left side of the temple/eyebrow area. A skin tear to the left elbow was also noted.</p>		5. These systematic changes will be completed by 6/30/13.	

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	<p>5.) During an interview with Resident #E on 5/31/13 at 1:15 p.m., she indicated she was in the Dining Room on 3/13/13, when Resident #B fell. She indicated she saw the resident walking around the table and fall. She indicated she knocked on the kitchen door to summon staff for help.</p> <p>6.) Resident #E's clinical record was reviewed on 5/31/13 at 2:00 p.m. The resident had a 3/27/13 quarterly MDS assessment. The assessment indicated Resident #E had a BIMS of 12 indicating the resident had moderate cognitive impairment.</p> <p>7.) Review of the current policy, dated 1/9/2008, titled "Fall Management Procedure," provided by the Administrator and the Director of Nursing on 5/31/13 at 9:00 a.m., included, but was not limited to, the following:</p> <p>"1. PURPOSE A. To assess all residents for risk factors that may contribute to falling and provide planned interventions...</p> <p>...2. PROCEDURE...</p>						

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	<p>...C. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls and/or injuries related to falls...."</p> <p>This federal tag relates to Complaint # 129644.</p> <p>3.1-45(a)(2)</p>			

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F009999	<p>Based on observation and interview, the facility failed to ensure there was an emergency call system in 1 of 1 Dining Rooms. This deficient practice had the potential to effect 53 of 53 living in the facility. (Resident #'s C, D)</p> <p>Findings include:</p> <p>Resident #C and Resident #D were observed sitting in the Dining Room from 11:01 a.m. to 11:20 a.m. on 5/30/13. There were no staff present.</p> <p>During an observation on 5/31/13 at 2:50 p.m., with Director of Nursing and the Inservice Director present, the Director of Nursing indicated there was no emergency call system in the Dining Room. The Inservice Director indicated there had never been a call system in the Dining Room.</p> <p>This Federal Tag relates to Complaint # IN00129644.</p> <p>3.1-19(u)(3)</p>	F009999			