

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
--	---

(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
F0000	<p>This visit was for the Investigation of Complaint IN00117171.</p> <p>Complaint IN00117171 substantiated, federal/state deficiencies related to the allegations are cited at F315 and F157.</p> <p>Survey date: October 31, 2012</p> <p>Facility number: 000398 Provider number: 155564 AIM number: 100291110</p> <p>Survey team: Marcy Smith RN TC</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 11 Medicaid: 39 Other: 14 Total: 64</p> <p>Sample: 3</p> <p>These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.</p>	F0000	The Mooresville facility respectfully requests paper compliance. Please accept the following plan of correction for F-Tag 157 and F-Tag 315 as our credible allegation of compliance.	

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: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Quality review completed 11/1/12 Cathy Emswiller RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
--	---

(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
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when a resident's urinary catheter was not functioning properly and when no urine output was noted for 1 of 3</p>	F0157	<p>F-157 It is the policy of Miller's Merry Manor, Mooresville to notify the physician of all condition changes that have the potential to require physician intervention.</p>	11/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158			
(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>residents reviewed for physician notification of changes in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident#A was reviewed on 10/31/12 at 9:45 a.m.</p> <p>Diagnoses for Resident #A included, but were not limited to, prostate cancer, urinary retention and neurogenic bladder.</p> <p>Resident #A was admitted to the facility on 9/11/12 from another nursing facility. He had a urinary catheter in place at the time of his admission.</p> <p>A "Catheter and Ostomy Assessment, dated 9/12/12 at 12:14 a.m., indicated Resident A had an indwelling urinary catheter for "Urinary retention that cannot be treated medically, surgically or with alternative therapy...". It indicated the catheter was inserted on 9/4/12. It indicated "res[ident] had leakage around cath site on admission."</p> <p>A nursing assessment dated 9/12/12 at 7:44 a.m. indicated Resident A's urinary catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/12/12 at 14:04 p.m. indicated Resident A's catheter</p>		<p>All residents in facility have potential to be affected. To ensure this does not reoccur a Mandatory Nursing In-service was scheduled on 11/7/12. The in-service included review of the policy titled "Physician & Family Notification of Condition Changes" (attachment 1), regarding the importance of notifying the physician with all changes in condition. All change of conditions will be added to the 24 Hour Condition Report sheet (attachment 2). Nursing unit managers or other designees will be responsible to review daily charting to ensure that Physician notification has been done and documented in the medical record.</p> <p>Upon hire all licensed nurses will complete the 11 day Charge Nurse Orientation program before working the floor (Attachment 6). This orientation covers Physician notification.</p> <p>The DON or other designees will be responsible to complete the QA tool titled " 24hour Condition Report" (attachment 3) daily x 2 weeks then weekly for 4 weeks then monthly thereafter for ongoing compliance. Any issues will be corrected immediately, recorded on a facility QA Tracking Log and reviewed in the facility QA Meeting monthly with any new recommendations implemented.</p> <p>Corrective actions will be completed by 11/8/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158		
(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>was patent and draining properly.</p> <p>A nursing assessment dated 9/12/12 at 3:35 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/13/12 at 3:19 a.m. indicated Resident A's catheter was not patent and/or draining properly.</p> <p>A nursing assessment dated 9/13/12 at 2:32 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/13/12 at 3:53 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/14/12 at 2:19 a.m. indicated Resident A's catheter was patent and draining properly.</p> <p>There was no documentation to indicate any interventions were attempted or implemented on 9/12/12 at 12:14 a.m. and 9/13/12 at 3:19 a.m. when it was documented the catheter was not patent and/or draining properly.</p> <p>There was no documentation to indicate a physician was notified about Resident A's catheter not functioning properly.</p> <p>A "Document Urinary output" report and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
--	---

(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 "Food and Fluid Intake" report for Resident A, received from the Director of Nursing (DON) on 10/31/12 at 11:30 a.m. indicated the following:</p> <p>On 9/12/12 his fluid intake was 3105 milliliters (mls). His urinary output was 150 mls at 9:34 p.m. There were no other output measurements for this date.</p> <p>On 9/13/12 his fluid intake was 2280 mls. His urinary output was 400 mls at 2:56 a.m., 75 mls at 5:19 a.m., 0 mls at 10:51 a.m. and 0 mls at 9:23 p.m.</p> <p>On 9/14/12 his fluid intake was 1160 mls. His urinary output was 50 mls.</p> <p>There was no documentation to indicate any staff had reviewed these reports or were aware Resident A had taken in 6545 mls in 3 days and had an output of only 675 mls or that he had no out put at all on several shifts.</p> <p>There was no documentation which indicated a physician had been notified about Resident A having no urine output noted on 9/13/12 at 10:51 a.m. and 9:23 p.m.</p> <p>A nursing note dated 9/14/12 at 9:31 a.m. indicated Resident A was unresponsive and had "black,sticky emesis..." He was transferred to the hospital at that time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158			
(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 facility policy, dated 2003-2012, titled "Output Monitoring," received from the DON on 10/31/12 at 2:15 p.m. indicated "...A. Output will be monitored each shift and documented in the medical record in Pont of Care...All residents will be monitored thru nursing on each shift for urine output. If a resident does not have a urine output on a given shift, the licensed nurse will be notified and will complete the "No Output" assessment..."</p> <p>This federal tag relates to complaint IN00117171.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158			
(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			
F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure a resident admitted with a urinary catheter was provided with assessments and interventions to prevent possible complications for 1 of 3 residents with urinary catheters reviewed for receiving ongoing assessment and interventions in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident#A was reviewed on 10/31/12 at 9:45 a.m.</p> <p>Diagnoses for Resident #A included, but were not limited to, prostate cancer, urinary retention and neurogenic bladder.</p> <p>Resident #A was admitted to the facility on 9/11/12 from another nursing facility. He had a urinary catheter in place at the time of his admission.</p>	F0315	<p>F-Tag 315</p> <p>It is the policy of Miller's Merry Manor, Mooresville to monitor output from urinary catheters by documenting every shift daily in the medical record. All residents with a urinary catheter were checked on 10/31/12 and all have appropriate assessments and interventions to prevent possible complications.</p> <p>To ensure this does not reoccur a Mandatory Nursing In-service was scheduled on 11/7/12. The in-service included review of the policy titled "Output Monitoring" (attachment 4),</p> <p>Charting output/ input on residents with urinary catheters will be placed on 24 hour condition report (attachment 2) and information will be passed on to every shift daily.</p> <p>Nurses will verify urinary output is documented every shift in EMR and signoff in treatment administration record. If any calculated/measured discrepancies of intake and urinary</p>	11/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158			
(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 "Catheter and Ostomy Assessment, dated 9/12/12 at 12:14 a.m., indicated Resident A had an indwelling urinary catheter for "Urinary retention that cannot be treated medically, surgically or with alternative therapy...". It indicated the catheter was inserted on 9/4/12. It indicated "res[ident] had leakage around cath site on admission."</p> <p>A nursing assessment dated 9/12/12 at 7:44 a.m. indicated Resident A's urinary catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/12/12 at 14:04 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/12/12 at 3:35 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/13/12 at 3:19 a.m. indicated Resident A's catheter was not patent and/or draining properly.</p> <p>A nursing assessment dated 9/13/12 at 2:32 p.m. indicated Resident A's catheter was patent and draining properly.</p> <p>A nursing assessment dated 9/13/12 at 3:53 p.m. indicated Resident A's catheter was patent and draining properly.</p>		<p>output are identified by the nurses, they will report findings to Director of Nursing.</p> <p>Upon hire all licensed nurses will complete the 11 day Charge Nurse Orientation program before working the floor (Attachment 6). This orientation covers Intake and Output procedures.</p> <p>The DON or other designees will be responsible to complete the QA tool titled "output monitoring" (attachment 5) daily x 2 weeks then weekly for 4 weeks then monthly thereafter for ongoing compliance. Any issues will be corrected immediately, recorded on a facility QA Tracking Log and reviewed in the facility QA Meeting monthly with any new recommendations implemented.</p> <p>Corrective actions will be completed by 11/8/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158
--	---

(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 nursing assessment dated 9/14/12 at 2:19 a.m. indicated Resident A's catheter was patent and draining properly.</p> <p>There was no documentation to indicate any interventions were attempted or implemented on 9/12/12 at 12:14 a.m. and 9/13/12 at 3:19 a.m. when it was documented the catheter was not patent and/or draining properly.</p> <p>A "Document Urinary output" report and a "Food and Fluid Intake" report for Resident A, received from the Director of Nursing (DON) on 10/31/12 at 11:30 a.m. indicated the following:</p> <p>On 9/12/12 his fluid intake was 3105 milliliters (mls). His urinary output was 150 mls. On 9/13/12 his fluid intake was 2280 mls. His urinary output was 475 mls On 9/14/12 his fluid intake was 1160 mls. His urinary output was 50 mls.</p> <p>There was no documentation to indicate any staff had reviewed these reports or were aware Resident A had taken in 6545 mls in 3 days and had an output of only 675 mls.</p> <p>A nursing note dated 9/14/12 at 9:31 a.m. indicated Resident A was unresponsive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and had "black,sticky emesis..." He was transferred to the hospital at that time.</p> <p>During an interview with Licensed Practical Nurse #1 on 10/31/12 at 1:15 p.m. she indicated when Resident A was admitted she noted his catheter was leaking around the insertion site. She indicated the staff at the facility he came from had indicated his catheter was leaking and he probably needed a larger size. She indicated she did not have any larger size catheters so she requested some be ordered. She indicated if a resident's catheter is leaking "we usually try to take the old one out and put a new one in." She indicated she thought about it later and "we should have just put a different one in, the same size."</p> <p>An packing slip, received from RN #2, who placed an overnight order for the catheters, indicated the larger size catheters arrived at the facility on 9/13/12 at 2:00 p.m. There was no documentation to indicate an attempt had been made to replace Resident A's leaking catheter with a new one.</p> <p>During an interview with the DON on 10/31/12 at 2:05 p.m. she indicated if a resident's catheter was leaking it should be removed and a new catheter anchored. She indicated she did not know why staff</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 259 W HARRISON ST MOORESVILLE, IN 46158		
(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>did not try to anchor one of the larger catheters when they were delivered to the facility on 9/13/12.</p> <p>This federal tag relates to complaint IN00117171.</p> <p>3.1-41(a)(1)</p>				