

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 730 SCHOOL ST CULVER, IN 46511
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 14, 15, 16, 17, and 18, 2014</p> <p>Facility number: 000489 Provider number: 155589 AIM number: 100291210</p> <p>Survey team: Sharon Ewing, RN-TC Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 6 Medicaid: 36 Other: 21 Total: 63</p> <p>Miller's Merry Manor of Culver was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Recertification and State Licensure Survey. This deficiency reflects state findings in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000223 SS=A	<p>Quality Review completed on December 26, 2014, by Brenda Meredith, R.N.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to prevent an episode of abuse in 1 of 3 incidents of allegation of abuse reviewed. (Resident # 27)</p> <p>Finding includes:</p> <p>On 12-17-14 at 8:00 A.M., the facility provided a copy of a report of an incident of alleged abuse from 11-15-14 at 1:20 P.M., The Incident Report that was filed with the Indiana State Department of Health, by the facility, for an incident that occurred on 11-15-14 at 1:20 P.M., indicated, "...CNA#1[name-Certified Nursing Assistant] and CNA #2[name,Certified Nursing Assistant] were assisting Resident #27[name, Resident #27] to the bathroom when Resident #27 began to spit and then bit</p>	F000223	All residents residing in the facility have the potential to be affected by this finding. To ensure this does not recur, we will be having inservices on Resident Abuse and Handling Behaviors with all new hires, along with quarterly inservices with current staff. The first inservice was completed immediately after the reported abuse on 11/17/2014. We will continue to inservice all staff as part of our Quarterly QA program. Inservice Director will conduct the next abuse inservice and QA review on 1/22/2015. We will monitor the effectiveness of these meetings by having staff participate in hands on demonstrations during the inservices on what to do, and how to correctly handle the situation when a resident becomes aggressive. Monitoring for	12/19/2014			

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	<p>CNA #1's breast. CNA #1 struck her head against Resident #27's head purposefully to stop her from biting. CNA#2 separated the resident [Resident #27] from CNA #1. Incident was immediately reported to nurse supervisor [name, LPN #3]. When LPN #3 asked CNA #1 what had happened, CNA#1 stated it just happened "automatically... Type of Injury/Injuries: Resident has no visible injuries...Immediate Action Taken: Resident was immediately removed from situation and assessed. Both aides were interviewed and CNA#1 was escorted out of the facility. MD [Medical Doctor] and family were called and aware. Neurochecks initiated on Resident. Local authorities notified and completing appropriate investigation...Preventative Measures Taken: CNA#1 terminated. Will initiate mandatory abuse inservice to all employees starting on Monday November 17th and completed by November 21st...Follow up 11-17-14 This letter is a summary of the incident that originally occurred on 11-15-14 involving an incident with a CNA [name, of Certified Nursing Assistant]. CNA was assisting {name of Resident} to the restroom when she bit her breast and [name of CNA #1] struck her with her head to try and stop her from biting. [name of CNA #2] immediately removed [name of CNA#1] from the room and</p>		<p>effectiveness will be done monthly for 6 months and then quarterly by Inservice Director through the facility QA Program. (see attachment)Do to the S/S of this tag we are respectfully requesting paper compliance for this finding. Thank you.</p>	

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	<p>reported what she witnessed to the Supervisor [name of LPN #3]. [Name of Resident #27] was assessed and no visible injuries were noted. [LPN#3] took [Name of CNA #1] into the conference room and asked her what happened and she said when [name of Resident #27] bit her breast she automatically hit her with her head. [Name, LPN #3] then escorted [name of CNA#1] out of the building. [Name of LPN #3] then notified me, the DON [Director of Nurses] and then I [DON] notified the Administrator [Name of Administrator]. The [local] Police Department was called and a report filed. The family was called and did not want to press charges. The Dr. [Doctor] was called and updated about the incident. [Name of Resident #27] does not remember the incident and still has no visible injury. [Name of CNA #1] was terminated for abuse. In-services will be held throughout this week on behaviors and abuse and will be completed by November 21, 2014...."</p> <p>On 12/17/14 at 8:05 A.M., the DON (Director of Nursing) was interviewed. The DON indicated a nurse immediately notified her and the Administrator of the incident. The nurse indicated she had ensured the resident was safe and removed the C.N.A. from the situation and the family and physician were also</p>						

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	<p>notified of the incident. The local police depart was also notified. The facility and the police started an investigation. The C.N.A. was escorted out of the building and later terminated. The facility immediately began to inservice the staff related to abuse. The Ombudsman, APS (Adult Protective Services) and ISDH (Indiana State Department of Health) were notified.</p> <p>On 12-17-14 at 8:15 A.M., review of ..." Abuse Investigation Worksheet: Reasonable Suspicion of a Crime...." provided by Director of Nurses, included but was not limited to the following: ..." Resident involved:[name, Resident #27]...Date of Incident: 11-15-14...Time of Incident: 1:20 P.M.,...Suspicion of Crime...Law enforcement notified: yes [square box with checkmark]...Date/Time Notified: 11-15-14...Name of Agency & Person contacted: Culver Police Department [name of officer responding to call]...Final report to Ombudsman submitted within 5 days (attach copy) Date submitted: 11-15-14...Final report to APS [Adult Protective Services] submitted within 5 days (attach copy) Date submitted: 11-15-14...."</p> <p>On 12/17/14 at 1:45 P.M., LPN #3 was interviewed. LPN #3 indicated she was working and staff came to her and told</p>						

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	<p>her of the incident. She indicated she made sure the resident was safe and removed the C.P.A. from the situation and took her off of resident care. She then notified the DON and the Administrator.</p> <p>On 12-18-14 at 2:00 P.M., record review of the policy " Nursing Manuals Subject: Abuse Prohibition, Reporting, and Investigation" provided by the Director of Nurses on 12-17-14 at 9:15 A.M., indicated, but was not limited to the following: ..." 1. A. It is the policy of Miller's Health Systems that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. B. Miller's Health Systems has policies and procedures in place that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property....."</p> <p>3.1-27 (a)(1)</p>				