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 01/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	524 ANDERSON RD CHESTERFIELD, IN 46017

(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	This visit was for the Investigation of Complaint IN00142116. Complaint IN00142116-Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: January 21 and 22, 2014 Facility number: 000524 Provider number: 155617 AIM number: 100267090 Surveyor: Betty Retherford, RN Census bed type: SNF/NF: 47 SNF: 1 Total: 48 Census payor type: Medicare: 5 Medicaid: 29 Other: 14 Total: 48 Sample: 7 These deficiencies also reflect state findings cited in accordance with	F000000	Please accept the enclosed plan of correction as credible allegation of compliance for the deficiency cited (F323) during the investigation of complaint IN00142116 survey conducted on January 21st and January 22nd, 2014. We respectfully request consideration for paper compliance for our submitted plan of correction. Should you have and questions or need additional information, please do not hesitate to contact me at 765-378-0213. Thank you, Lindsey Hart-Administrator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	410 IAC 16.2. Quality review completed by Debora Barth, RN.			
F000323 SS=D	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, record review, and interview, the facility failed to ensure interventions identified in the residents' plan of care were in place to help prevent potential falls for 2 of 4 residents reviewed for fall safety in a sample of 7. (Resident #C and #H) Findings include: 1.) The clinical record for Resident #C was reviewed on 1/21/14 at 10:15 a.m. Diagnoses for the resident included, but were not limited to, altered mental status with history of delusions, hallucinations, and paranoia, neuropathy, and diabetes mellitus. A quarterly Minimum Data Set	F000323	It is the policy of Miller's Merry Manor-Chesterfield to ensure each resident receives adequate supervision and assistant devices to prevent accidents from occurring. All residents whom have a fall prevention care plan have the potential to be affected by this deficient practice. An audit was conducted on 1/22/14-1/24/14 by the Don and nurse management team. During the audit each resident's fall prevention care plan was reviewed and fall prevention items in place per care plan. Residents are assessed upon admission, quarterly, and when any significant change(s) occurs, to identify their potential of fall risk. All C.N.A.'s are provided with resident assignment sheets. These C.N.A. assignment sheets reflect fall risk interventions. C.N.A. assignment sheets are updated at least weekly, prn as needed, or when changes occur. An all staff in-service was held on	02/08/2014

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	(MDS) assessment, dated 12/17/13, indicated Resident #C was moderately cognitively impaired and required extensive assistance from the staff for transfers, ambulation, and toileting. A health care plan problem, revised on 11/15/13, indicated Resident #C was at risk for falls related to a history of falls, weakness, and unsteady gait. One of the approaches for this problem was for the resident to have a safety alarm in place on her recliner and/or wheelchair when out of bed. A physician's order, dated 11/7/13, indicated Resident #C was to have a pressure alarm on her recliner chair and/or wheelchair when out of bed. An "Occurrence Initial Assessment", dated 12/22/13 at 9 p.m., indicated Resident #C had been found on the floor in her room. The resident was found sitting on her "bottom" with her legs stretched out in front of her in front of her recliner. No injuries were noted and the resident had no complaints of pain or discomfort. The initial occurrence report previously noted and subsequent nursing notes and post fall		1/22/14 to re-educate staff on assistant devices and their proper placement and assembly. Resident C was re-assessed, evaluation by the DON and nurse management team concluded resident C still needs a personal alarm for their safety. Resident H was re-evaluated and after assessment alarm was no longer necessary and discontinued on 1/22/14. In order to prevent the deficient practice in the future, the facility will re-educate all nursing staff by 2/7/14 on fall prevention and the use of personal alarms. C.N.A.'s will be re-educated on C.N.A. assignment sheets and the info provided on those sheets. To ensure compliance with this corrective measure, the DON or designee will complete QA tool Personal Alarm Review (attachment A) 3x per week for 3 weeks, then 1x week for 3 weeks, and then monthly thereafter. Any issues found will be corrected immediately and placed on a QA log to be reviewed by the QA committee at the monthly meeting. Corrective action will be completed by 2/08/14.	

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	assessments lacked any information related to whether the resident's pressure alarm was in place as ordered by the physician and sounding at the time of the fall. During an interview on 1/22/14 at 12:20 p.m., the DoN indicated she had reviewed the facility incident records and the alarm cord had not been connected to the alarm box at the time of the resident's fall and the alarm had not sounded. During an observation on 1/21/14 at 2:05 p.m., Resident #C was sitting up in her recliner in her room. The alarm box of her pressure alarm was observed on the bedside table. No cord was observed going from the alarm box to the pressure pad underneath the resident. During an observation with the DoN on 1/21/14 at 2:07 p.m., she picked up the cord from beside the resident's chair and attached it to the alarm box on the bedside table. She then ensured the alarm was turned on and attached the alarm box to the back of the resident's chair. During an interview with the DoN on 1/21/14 at 2:07 p.m., she indicated			

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	the alarm box had not been attached to the cord leading to the pressure pad and no alarm would not have sounded if the resident had attempted to get up without assistance. 2.) The clinical record for Resident #H was reviewed on 1/22/14 at 11:30 a.m. Diagnoses for the resident included, but were not limited to, anemia, renal failure, debility, depressive disorder, and hypertension. A quarterly MDS assessment, dated 12/24/13, indicated Resident #H was moderately cognitively impaired and required extensive assistance from the staff for transfers, ambulation, and toileting. A health care plan problem, revised on 5/8/13, indicated Resident #H was at risk for falls related to a history of falls, weakness, and peripheral vascular disease. One of the approaches for this problem was for the resident to have a personal alarm in place on her wheelchair when out of bed. A recapitulation of physician's orders, signed 12/12/13, indicated			

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	Resident #H was to have a personal alarm on her wheelchair when out of bed. During an observation with CNA #1 on 1/22/14 at 11:15 a.m., Resident #H was up in her wheelchair in the hall and the clip to her personal safety alarm was hanging down behind the wheelchair. CNA #1 picked up the clip of the safety alarm and attached it to the back of the resident's clothing. During an interview with CNA #1 on 1/22/14 at 11:15 a.m., she indicated the clip on the alarm string should have been attached to the back of the resident's clothing in order for it to be pulled loose and sound if the resident attempted to get up unassisted. 3.) Review of the current facility policy, dated 1/9/08, titled "Fall Management Procedure", provided by the DoN on 1/22/14 at 9:15 a.m., included, but was not limited to, the following: "1. Purpose A. To assess all residents for risk factors that may contribute to falling and to provide planned interventions			

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	identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible.... 2. Procedure ...C. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing falls and/or injuries related to falls.... This federal tag relates to Complaint IN00142116. 3.1-45(a)(2)			