

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  03/12/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F000000	<p>This visit was for Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00142108 and IN00142323 completed on January 23, 2014.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaint IN00141207 completed on December 17, 2013.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00143744 and IN00145184.</p> <p>Complaints IN00142108 and IN00142323- not corrected.</p> <p>Survey dates: March 10, 11, &amp; 12, 2014.</p> <p>Facility number: 000018 Provider number: 155053 AIM number: 100273930</p> <p>Survey Team: Angel Tomlinson, RN, TC Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type:</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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	<p>SNF: 5 SNF/NF: 54 Residential: 21 Total: 80</p> <p>Census Payor type: Medicare: 3 Medicaid: 55 Other: 22 Total: 80</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 19, 2014, by Janelyn Kulik, RN.</p>						

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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 observation, interview and record review the facility failed to ensure care plans and physician orders were followed for 2 of 3 residents reviewed in a sample of 6 related to fall interventions being in place and following the physician order to notify the physician of blood pressures that were out of the parameters (Resident #F &amp; Resident #A).</p> <p>Findings include:</p> <p>1. During an interview on 3-10-14 at 1:52 p.m. Resident #F indicated the last fall she had she was transferring out of the bed to the wheelchair and either she had slid or the bed slid. The resident indicated she was unsure which one. An observation of the resident's bed at this time indicated there were no wood blocks under the resident's wheels of her bed.</p> <p>Review of the record for Resident #F on 3-10-14 at 3:06 p.m. indicated the resident's diagnoses included, but</p>	F000282	<p>1) Resident #A's POA was notified of all blood pressure reading outside of parameters on 3.4.14. Resident #A received a new order on 3.11.14 for a change in her blood pressure medication related to low blood pressure readings .Resident #F was affected by the deficient practice. No injury occurred. CNA #1 counseled on following the CNA assignment sheet (Attachment # 7). Resident #F's room rearranged to prevent unwanted bed movement. 2) Other residents with parameters for blood pressure and physician notification have the potential to be affected by this deficient practice. 100% audit completed to asses for residents requiring Physician and Family notification of blood pressure readings outside set parameters. All residents have the potential to be affected by this deficient practice if the incorrect number of assistance is used with transfers, ambulation, and care. 100% audit completed to ensure the proper number of staff required for safe care is documented on the CNA assignment sheet (Attachment # 7) and resident plan of care. 100% audit of fall</p>	03/22/2014	

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	<p>were not limited to, congestive heart failure, anxiety, malaise and fatigue, osteoporosis, depression, seizure disorder, unspecified debility and morbid obesity.</p> <p>The Quarterly Minimum Data (MDS) Assessment for Resident #F dated, 12-4-13 indicated the resident required extensive assistance of two people to transfer.</p> <p>The fall risk care plan for Resident #F dated, 2-21-14 indicated the resident had multiple risk for falls due to seizure disorder, weakness, history of a foot fracture, osteoporosis and a hearing deficit. The interventions included, but were not limited to, the resident to be transferred with the assistance of two staff members at all times and will have bed chucked with wood blocks by maintenance.</p> <p>The occurrence initial assessment for Resident #F dated, 3-1-14 at 7:10 a.m. indicated the resident had a fall with no injury. The resident had to be lowered to the floor while getting the resident up.</p> <p>The post occurrence assessment for Resident #F dated, 3-3-14 indicated the resident was being transferred from her bed to the wheelchair with</p>		<p>interventions completed to ensure all fall interventions are current and implemented. 3) All nursing re-educated 3.17.14 on Physician and Family Notification of Condition Change policy and procedure (Attachment # 5) and on the Care plan Development and Review Policy and Procedure (Attachment#8) to ensure physician notification of any blood pressure readings outside ordered parameters, to ensure responsible parties are notified of any change in condition and any new orders and to ensure the plan of care is followed. All nursing re-educated 3.17.14 on the use of CNA assignment sheets (Attachment # 7 ) and on the Care Plan Development and Review Policy and Procedure (Attachment # 8) to ensure staff awareness of proper number of staff required to provide care, transfer, or walking assistance and to ensure awareness of fall interventions listed in the resident plan of care. 4)Corrective action will be QA monitored using the Physician Notification audit tool (Attachment #6) to ensure any resident with blood pressure readings outside of the set parameters will have these results called to the Physician for any necessary changes, and responsible parties will be notified and plan of care followed.. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x</p>		

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	<p>assistance of one person. The resident was lowered to the floor. The root cause of the fall was the resident was being transferred incorrectly.</p> <p>Interview with the Director Of Nursing on 3-11-14 at 11:45 a.m. indicated Resident #F fell on 3-1-14 because the resident was being transferred by CNA #1 and there should have been two staff transferring the resident. The DON indicated Resident #F told her the reason that she fell was because she just couldn't stand.</p> <p>Interview with CNA #1 on 3-11-14 at 12:03 p.m. indicated on 3-1-14 when Resident #F fell, the resident told her she could transfer with one person. CNA #1 indicated she had a gait belt on the resident and went to stand the resident up from the bed to transfer her into the wheelchair and the bed was not locked and slid away from the resident. CNA #1 indicated she guided the resident to the floor with the gait belt.</p> <p>During an observation on 3-11-14 at 12:13 p.m. with the Maintenance Supervisor, Resident #F's bed did not have wood blocks under the resident's wheels of her bed. The Maintenance Supervisor indicated at this time he had not received a work</p>		<p>3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Corrective action will be QA monitored using the Care Plan/ Assignment Sheet audit tool (Attachment #9.) The QA tool Care Plan/ Assignment Sheet audit tool (Attachment #9 ) will be used to ensure staff are using the proper number of staff to provide care, transfer, or walking assistance and to ensure fall interventions are implemented. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>				

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	order for the resident to have her bed chucked with wood blocks. The Maintenance Supervisor indicated he did not use wood blocks to chuck beds, that he used rubber stoppers and he would put some in place.			

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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>2. Resident #A's record was reviewed on 3/11/14 at 9:00 A.M. The resident's diagnoses included but were not limited to, anoxic brain damage, quadriplegia, and seizure disorder.</p> <p>Resident #A's Annual Minimum Data Set (MDS) Assessment dated 2/12/14, indicated Resident #A had unclear speech. She was usually understood and she understood others. She received tracheostomy suctioning and care.</p> <p>Resident #A's March 2014 Recapitulation order, initiated 1/28/13, indicated the following: The physician would be notified of a systolic blood pressure (measures the pressure in the arteries when the heart beats) reading below 90 or above 160 or a diastolic blood pressure (measures the pressure in the arteries between heart beats) reading below 50 or above 90.</p> <p>A review of Resident #A's blood pressure readings indicated the</p>	F000282	<p>1) Resident #A's POA was notified of all blood pressure reading outside of parameters on 3.4.14. Resident #A received a new order on 3.11.14 for a change in her blood pressure medication related to low blood pressure readings .Resident #F was affected by the deficient practice. No injury occurred. CNA #1 counseled on following the CNA assignment sheet (Attachment # 7). Resident #F's room rearranged to prevent unwanted bed movement. 2) Other residents with parameters for blood pressure and physician notification have the potential to be affected by this deficient practice. 100% audit completed to asses for residents requiring Physician and Family notification of blood pressure readings outside set parameters. All residents have the potential to be affected by this deficient practice if the incorrect number of assistance is used with transfers, ambulation, and care. 100% audit completed to ensure the proper number of staff required for safe care is documented on the CNA assignment sheet (Attachment # 7) and resident plan of care. 100% audit of fall</p>	03/22/2014			

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	<p>following blood pressures: On 1/7/14 her blood pressure reading was 82/54. On 1/29/14 her blood pressure reading was 86/52. On 1/30/14 her blood pressure reading was 83/54. On 2/28/14 her blood pressure reading was 84/54. No documentation was available indicating the physician had been notified of Resident #A's blood pressure readings on 1/7/14, 1/29/14, or 1/30/14.</p> <p>On 3/11/14 at 9:56 A.M., LPN #4 indicated the physician was not notified of Resident #A's blood pressure readings on 1/29/14, or 1/30/14. She indicated the physician was notified of Resident #A's blood pressure reading 2/28/14, on 3/3/14. LPN #4 indicated if the Resident #A showed no signs or symptoms of distress or illness the facility would fax the blood pressure results. She indicated after 5:00 P.M., the fax would be sent the next morning and after 5:00 P.M., on Friday the fax would be sent the following Monday. LPN #4 was unable to provide documentation the physician was notified of Resident #A's blood pressure readings on 1/7/14, 1/29/14, and 1/30/14.</p> <p>This deficiency was cited on</p>		<p>interventions completed to ensure all fall interventions are current and implemented. 3) All nursing re-educated 3.17.14 on Physician and Family Notification of Condition Change policy and procedure (Attachment # 5) and on the Care plan Development and Review Policy and Procedure (Attachment#8) to ensure physician notification of any blood pressure readings outside ordered parameters, to ensure responsible parties are notified of any change in condition and any new orders and to ensure the plan of care is followed. All nursing re-educated 3.17.14 on the use of CNA assignment sheets (Attachment # 7 ) and on the Care Plan Development and Review Policy and Procedure (Attachment # 8) to ensure staff awareness of proper number of staff required to provide care, transfer, or walking assistance and to ensure awareness of fall interventions listed in the resident plan of care. 4)Corrective action will be QA monitored using the Physician Notification audit tool (Attachment #6) to ensure any resident with blood pressure readings outside of the set parameters will have these results called to the Physician for any necessary changes, and responsible parties will be notified and plan of care followed.. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x</p>				

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	12/17/13. The facility failed to implement a systemic plan of correction to prevent recurrence.  3.1-35(g)(2)		3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented. Corrective action will be QA monitored using the Care Plan/ Assignment Sheet audit tool (Attachment #9.) The QA tool Care Plan/ Assignment Sheet audit tool (Attachment #9 ) will be used to ensure staff are using the proper number of staff to provide care, transfer, or walking assistance and to ensure fall interventions are implemented. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.	

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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 observation, interview and record review the facility failed to transfer a resident with the assistance of two staff, failed to implement a fall intervention of wood blocks under a resident's bed and failed to have the bed locked during a transfer resulting in a resident falling for 1 of 3 residents sampled for falls in a total sample of 6 (Resident #F).</p> <p>Finding include:</p> <p>During an interview on 3-10-14 at 1:52 p.m. Resident #F indicated the last fall she had she was transferring out of the bed to the wheelchair and either she had slid or the bed slid. The resident indicated she was unsure which one. An observation of the resident's bed at this time indicated there were no wood blocks under the resident's wheels of her bed.</p> <p>Review of the record for Resident #F on 3-10-14 at 3:06 p.m. indicated the resident's diagnoses included, but</p>	F000323	<p>1)Resident #F was affected by the deficient practice. No injury occurred. CNA #1 counseled on following the CNA assignment sheet (Attachment # 7). Resident #F's room rearranged to prevent unwanted bed movement. 2) All residents have the potential to be affected by this deficient practice if the incorrect number of assistance is used with transfers, ambulation, and care. 100% audit completed to ensure the proper number of staff required for safe care is documented on the CNA assignment sheet (Attachment # 7) and resident plan of care. 100% audit of fall interventions completed to ensure all fall interventions are current and implemented. 3) All nursing re-educated 3.17.14 on the use of CNA assignment sheets (Attachment # 7 ) and on the Care Plan Development and Review Policy and Procedure (Attachment # 8) to ensure staff awareness of proper number of staff required to provide care, transfer, or walking assistance and to ensure awareness of fall interventions listed in the resident plan of care. 4) Corrective action will be QA monitored using</p>	03/22/2014			

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	<p>were not limited to, congestive heart failure, anxiety, malaise and fatigue, osteoporosis, depression, seizure disorder, unspecified debility and morbid obesity.</p> <p>The Quarterly Minimum Data (MDS) Assessment for Resident #F dated, 12-4-13 indicated the resident required extensive assistance of two people to transfer.</p> <p>The fall risk care plan for Resident #F dated, 2-21-14 indicated the resident had multiple risk for falls due to seizure disorder, weakness, history of a foot fracture, osteoporosis and a hearing deficit. The interventions included, but were not limited to, the resident to be transferred with the assistance of two staff members at all times and will have bed chucked with wood blocks by maintenance.</p> <p>The occurrence initial assessment for Resident #F dated, 3-1-14 at 7:10 a.m. indicated the resident had a fall with no injury. The resident had to be lowered to the floor while getting the resident up.</p> <p>The post occurrence assessment for Resident #F dated, 3-3-14 indicated the resident was being transferred from her bed to the wheelchair with</p>		<p>the Care Plan/ Assignment Sheet audit tool (Attachment #9.) The QA tool Care Plan/ Assignment Sheet audit tool (Attachment #9 ) will be used to ensure staff are using the proper number of staff to provide care, transfer, or walking assistance and to ensure fall interventions are implemented. This QA tool will be used by the DON or designee daily x 30days, 2 x's weekly x 4 weeks and monthly x 3 months. Then monthly thereafter until audit shows 100% compliance x 3 months. The results will be reviewed by the Quality Assurance Committee and any recommendations will be implemented.</p>		

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	<p>assistance of one person. The resident was lowered to the floor. The root cause of the fall was the resident was being transferred incorrectly.</p> <p>The fall risk assessment for Resident #F dated, 3-3-14 indicated the resident had confusion/forgetfulness, weakness, uses assistive device for mobility, unsteady gait with or without assistive devices, had impaired balance with transfers with or without assistive devices, requires staff to physically support her while transferring.</p> <p>Interview with the Director Of Nursing on 3-11-14 at 11:45 a.m. indicated Resident #F fell on 3-1-14 because the resident was being transferred by CNA #1 and there should have been two staff transferring the resident. The DON indicated Resident #F told her the reason that she fell was because she just couldn't stand.</p> <p>Interview with CNA #1 on 3-11-14 at 12:03 p.m. indicated on 3-1-14 when Resident #F fell, the resident told her she could transfer with one person. CNA #1 indicated she had a gait belt on the resident and went to stand the resident up from the bed to transfer her into the wheelchair and the bed was not locked and slid away from</p>			

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	<p>the resident. CNA #1 indicated she guided the resident to the floor with the gait belt.</p> <p>During an observation on 3-11-14 at 12:13 p.m. with the Maintenance Supervisor, Resident #F's bed did not have wood blocks under the resident's wheels of her bed. The Maintenance Supervisor indicated at this time he had not received a work order for the resident to have her bed chucked with wood blocks. The Maintenance Supervisor indicated he did not use wood blocks to chuck beds, that he used rubber stoppers and he would put some in place.</p> <p>Interview with the MDS Coordinator on 3-11-14 at 12:16 p.m. indicated it was the responsibility of the Unit Manager and DON to ensure fall interventions were in place.</p> <p>The fall management procedure provided by the DON on 3-11-14 at 3:00 p.m. indicated "the purpose was to assess all residents for risk factors that may contribute to falling and to provide planned interventions 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."</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  03/12/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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(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
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	<p>This deficiency was cited on 12-17-13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>			
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