STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY HEALTH & REHABILITATION CENTER	502 W JACKSON ST MULBERRY, IN 46058

(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	This visit was for the Recertification and State Licensure Survey. Survey dates: December 11, 12, 13, 14, 17, and 18, 2012 Facility Number: 000470 Provider Number: 155600 Aim Number: 100289210 Survey Team: Tammy Alley RN TC Rita Mullen RN Michelle Carter RN Census Bed Type: SNF: 27 SNF/NF: 102 Residential: 4 Total: 133 Census Payor Type: Medicare: 21 Medicaid: 78 Other: 34 Total: 133 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/18/12 Cathy Emswiller RN	F0000	Mulberry Health & Retirement Community respectfully request to have a desk review in lieu of a follow up on sight survey.	

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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NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to refer a resident,with a decline in Activities of Daily Living (ADL), to therapy as per the care plan. This affected 1 of 3 residents reviewed for ADL decline in a sample of 3. (Resident #99) Findings include: The clinical record of Resident #99 was reviewed on 12/13/12 at 10:00 A.M. Diagnoses included, but were not limited to, high blood pressure, depression with anger, degenerative joint disease and dementia with behaviors. A Care Plan for Requiring Assistance with ADL's due to dementia and degenerative joint disease, dated 10/6/10 and updated quarterly, indicated approaches, included but were not limited to, needs cuing for washing and notify physical therapy of a decline in ADL's.	F0282	Therapy will screen the identified resident in the 2567 for a decline in ADL's. All residents with a decline in ADL's have the potential to be affected. Those noted to have a decline in the past six months will be audited to ensure therapy screens have occurred. MDS Director will notify in writing Therapy Director following every MDS completion for a resident that a decline in ADL's is identified. Therapy Director will follow through to ensure therapy screen is completed. Therapy Director will audit weekly for the first four weeks all residents identified with a decline in ADL's to ensure therapy screen is complete. Thereafter once a month for five months Therapy Director will audit 10% of the residents identified with a decline in ADL's to ensure therapy screen is complete. Therapy Director will report monthly to the facilities QAA committee the results of the audit. A compliance threshold of 100% has been established by the governing QAA committee to ensure a measurable system is in place not only to ensure ongoing compliance, but to	01/11/2013

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	155600	A. BUILDING 00 B. WING	12/18/2012

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	A Quarterly Minimum Data Set (MDS) assessment, dated 6/17/12, indicated Resident #99 required set-up only for dressing. A Quarterly MDS assessment, dated 9/16/12, indicated Resident required the extensive assist of one for dressing. This was a decline of two levels. During an interview with Physical Therapist #4, on 12/14/12 at 10:30 A.M., he indicated there was no record of Resident #99 receiving an evaluation for a decline in ADL's during the month of September 2012. During an interview with LPN #2, on 12/14/12 at 10:55 A.M., she indicated nursing should have referred Resident #99 to therapy for an evaluation if his ADL's had declined. The system didn't work. 3.1-35(g)(2)		effectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance thresholds are not achieved with in the first six months then the monitoring period will be extended to a level found appropriate by the QAA committee.	