STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	815 W WASHINGTON ST ROCKPORT, IN 47635

(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 a Recertification and State Licensure Survey Survey dates: January 08, 09, 10, 13, 14, 15, 2014 Facility number: 000174 Provider number: 155274 AIM number: 100274810 Survey team: Amy Wininger, RN, TC Terri Walters, RN Dorothy Watts, RN January 8, 9, 10, 13, 2014 Census bed type: SNF: 4 SNF/NF: 52 Total: 56 Census payor type: Medicare: 8 Medicaid: 36 Other: 12 Total: 56 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on January 21, 2014, by Jodi Meyer, RN	F000000	Please accept this credible allegation of compliance to the findings in our annual ISDH survey completed on January 15th, 2014. The facility respectfully requests to be considered for paper compliance revisit.	

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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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, interview, and record review, the facility failed to ensure supervision and /or monitoring was adequate and interventions were effective to prevent falls and injury for 1 of 3 residents reviewed for falls who met the criteria for accidents in stage 2. Resident #55 Findings include: On 1/15/14 at 10:30 A.M., Resident # 55 was observed in her room sitting in her wheel chair. An anti-roll device was observed on the back of her wheelchair. She had dycem (an anti-slip product) applied under the anti-pressure cushion of her wheelchair. On 1/15/14 at 10:30 A.M., CNA #1 who was assigned to care for Resident #55, indicated Resident #55 transfers herself. CNA #1 indicated the resident had gotten herself up that A.M. Review of CNA #1's assignment sheet indicated independent toileting and transfers for Resident #55.	F000323	Resident # 55 has a current care plan in place with safety interventions to “have assistance with all transfers”. C.N.A. assignment sheets have been updated to reflect the interventions. (Attachments A,B) All residents with falls will have their plan of care (including, but not limited to, physician’s orders, BIMS score, therapy recommendations, and fall care plan) reviewed for revised and/or accurate interventions and C.N.A. assignment sheets will be updated with any changes. This will ensure interventions are in place to provide adequate supervision as needed. All nursing staff and the interdisciplinary team will be inserviced on the Fall Management Policy & Procedure (Attachment C). A new fall review audit tool has been instituted and will be done with each fall to improve compliance. (Attachment D) The DON or designee will audit each fall daily for 30 days and then weekly thereafter utilizing the QA tool (Attachment D) and necessary corrections will be made	02/14/2014

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	Resident #55's clinical record was reviewed on 1/10/14 at 9:10 A.M. She had been admitted to the facility on 7/13/12. Her diagnoses (January 2014 physician orders) included, but were not limited to: aftercare healing traumatic fracture arm, unspecified osteoporosis, spinal stenosis lumber region, without neurogenic claudication, generalized anxiety disorder, polymyalgia rheumatica, and closed fracture of multiple cervical vertebrae without spinal cord injury. Her Minimum Data Set Assessment (MDS) dated 9/3/13, indicated a cognition score of 9 (8-12 moderate cognitive impairment), extensive assistance of 1 staff for transfers, and independent ambulation in room and corridor. Her current MDS dated 12/02/13,indicated a cognitive score of 11 (moderate impairment), and independent transfer and ambulation. Her current care plan which addressed fall risk had an initiation date of 7/14/12 and a revision date of 4/17/13, was received for review on 1/13/14 at 10:15 A.M. Interventions included but were not limited to: "...Analyze previous resident falls to determine whether pattern/trend can be addressed [Date		immediately. This tool will be used indefinitely. A summary of the results will be completed monthly and reviewed by the QA committee. Any trends identified will be addressed with appropriate staff.	

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	initiated 7/14/2012], Anti roll back device to w/c [wheelchair] [Date initiated 12/31/2013], Dycem on bottom of cushion in w/c. [Date initiated 11/2/2013 Revision on 1/8/2014], Encourage and assist with wearing non-skid foot-wear [Date initiated 7/14/2012], Has non skid strips to floor next to bed. [Date initiated 1/8/2014], Monitor for changes in gait/positioning [Date initiated 7/14/12], Notify MD of changes in condition [Date initiated 7/14/12], Reinforce need to call for assistance [Date initiated 7/14/2012], Resident has own personal bed from home in room. Box springs removed to lower bed. [Date initiated 4/17/2013], and Sign in room to cue resident to lock brakes of wheel chair prior to transfer [Date initiated 12/26/2013]..." A nursing documentation entitled occurrence initial assessment dated 9/3/13 at 6:00 P.M., indicated, "...Res [resident] was trying to reach an item off her bed and feet slid. Res was wearing only stocking on her feet. Moves all extremities without difficulty and no red or bruised areas noted. Explained to res importance of wearing proper footwear and res voiced understanding..." The assessment indicated no injury had occurred. "...IDT [Interdisciplinary Team] recommendations: Resident to			

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	wear proper foot wear of non skid socks while up out of bed." The current care plan indicated the intervention of proper footwear had previously been initiated on 7/14/12. Another fall occurred on 9/25/13 at 2:00 P.M. An occurrence initial assessment documentation dated 9/25/13 at 2:00 P.M., indicated, "...Resident noted on floor beside bed. Upon investigation-Resident sat on the side of the bed after napping. Resident did not have foot wear on although noted to have stockings on bilateral lower ext [extremity]. IDT recommendations: Resident noted with similar incident on 9/3/13 slipping from w/c while reaching for an item. IDT recommended footwear while OOB [out of bed]. After investigating this incident, IDT recommended placing dycem to floor to attempt to decrease chance of slipping when arising from bed." An occurrence initial assessment dated 11/2/13 at 1:30 P.M., indicated, "...Resident sitting in w/c, started sliding & slid out of w/c onto floor landing on buttocks. ROM [range of motion] done without diff. [difficulty]. No red or bruised areas noted. Denies hitting head. Another resident, [other resident's name here] was witness to fall & also			

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	stated resident did not hit head..." "IDT recommendations: Dycem to top and bottom of w/c cushion." An occurrence initial assessment dated 12/24/13 at 8:00 P.M., indicated a fall had occurred without injuries. A summary of the fall indicated, "Resident slid from her wheelchair due to brakes not locked on chair. Resident attempting to transfer from wheelchair without locking brakes." IDT recommendations: "Sign placed in resident's room reminding to lock wheelchair brakes. Reassess in 14 days if ineffective will place anti-rollback device on wheelchair." Another fall occurred on 12/31/13 at 6:45 P.M. The occurrence assessment indicated, "Call light ringing resident sitting on floor beside recliner facing her refrigerator. AROM [Active Range of Motion] to all ext. [extremities]. Denies hitting head..." "...Wheel chair rolling d/t [due to] failure to lock brakes. IDT recommendations: Anti Roll backs to w/c." On 1/15/14 at 9:30 A.M., during interview with the Assistant Director of Nursing (ADON), she indicated an x-ray on 10/7/13, indicated Resident #55 had a left hip fracture. She indicated			

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	documentation was lacking of a fall between the 9/25/13 and the 11/2/13 fall. She provided documentation of follow up nursing assessments entitled occurrence follow-up assessment for the 9/25/13 fall : 9/25/13 at 10:34 P.M., 9/26/13 at 9:13 A.M., 9/27/13 at 9:14 A.M., which indicated no new injury or pain. A weekly nursing assessment dated 9/28/13 at 2:59 A.M., indicated, "...Hurts a Little More [no site of pain documented]..." "...Is on routine pain med but cont [continued] to c/o [complaint] disc. [discomfort] MD aware..." An occurrence follow-up assessment dated 9/28/13 at 8:44 A.M., indicated no new injury and level of pain of "...Hurts a Little Bit [no site of pain documented]..." A weekly nursing assessment dated 9/28/13 at 7:07 P.M., indicated level of pain "...No Hurt..." A physician's progress note dated 10/2/13, indicated, "...no complaints of level pain..." A weekly nursing assessment dated 10/5/13, "...No Hurt..." On 1/15/14 at 9:40 A.M., during interview with the ADON, an x-ray report dated 10/7/13 was reviewed. The x-ray indicated, the reason for x-ray was "...pain in left hip..." "...Findings: there is a partially impacted subcapital fracture of the left hip Comment: fracture left hip." The ADON indicated			

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	at that time the facility did not investigate the left hip fracture. She also indicated after the resident returned from the hospital on 10/10/13, after a left hip repair. She indicated no new interventions were initiated to address the resident's safety needs. On 1/15/14 at 10:05 A.M., during interview with the Administrator, she indicated documentation was lacking of any changes on the CNA assignment sheets from before left hip fracture (10/7/13) and on return to the facility on 10/10/13. On 1/15/14 at 1:40 A.M., Physical Therapy Progress and Discharge Summary was received and reviewed. The start date of therapy was 10/10/13 and end of care was 12/4/13. "Discharge Plans & Instructions: Pt. (patient) plans to remain resident of [facility's name here] and have assistance from staff for all transfers and ambulation due to poor safety and decreased balance placing pt at risk for falls." On 1/15/14 at 11:35 A.M., during interview with the Administrator, she was made aware falls have continued after the resident returned to facility after a hip fracture (unknown cause of			

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	the hip fracture). She was also made aware new interventions and/or an updated safety plan for the resident had not occurred after readmission 10/7/13 (hip fracture). 3.1-45(a)(2)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to ensure the kitchen and kitchen equipment were clean and food was prepared under sanitary conditions in that, the ceiling, vent cover, and light fixture over the food preparation area were soiled and the inside of the oven was soiled during 2 of 3 kitchen observations. This had the potential to affect 56/56 residents who resided in the building. Findings include:	F000371	The ceiling, vent cover, and light fixture over food preparation area and the oven were all cleaned. The facility has updated cleaning schedules for the department and will educate all dietary staff on sanitation procedures and the new schedules. (Attachment E,F,G) The dietary sanitation will be monitored by the Dietary Manager or designee weekly for 4 weeks and then at least monthly thereafter. (Attachment H) Any necessary corrections will be made immediately or placed on a QA log to be scheduled for repair/cleaning. Results will be reviewed by the QA Committee	02/14/2014

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	The following was observed on 01/10/13 at 10:30 A.M.: 1. The ceiling and vent cover over the food preparation area was observed to be soiled with a black debris. 2. The light fixture over the food preparation area was observed to be soiled with multiple brown spots and brown/black debris was observed to be hanging from both sides. 3. The inside floor of the oven was observed to have built up black debris and the inner surface of the oven doors was observed to be covered with a thick brown grease film. During an interview, at that time, the HFA (Health Facilities Administrator) indicated she did not know what the soilage and debris were, but they would be cleaned up as soon as possible. The following was observed on 01/13/13 at 12:30 P.M.: 4. The ceiling and vent cover over the food preparation area was observed to be soiled with a black debris. 5. The light fixture over the food		and any trends identified will be addressed with appropriate staff.	

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	preparation area was observed to be soiled with multiple brown spots and brown/black debris was observed to be hanging from one side. 6. The inside floor of the oven was observed to have built up black debris and the inner surface of the oven doors were observed to be covered with a thick brown grease film. The Dietary Cleaning Schedule provided by HFA on 01/14/14 at 2:10 P.M., indicated there was no routine schedule for cleaning above the food preparation area and the oven should be cleaned daily. During an interview on 01/14/14 at 2:15 P.M., the HFA indicated the area over the food preparation area should be cleaned as needed and a routine schedule for oven cleaning should be followed. During an interview on 01/14/14 at 3:00 P.M., the HFA indicated there was not a specific policy related to cleaning above the food preparation area and the inside of the oven, but a monthly kitchen sanitation audit was completed on 12/13/13 and indicated both areas were clean.			

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F000431 SS=D	3.1-21(i)(2) 3.1-21(i)(3) 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F000431	The Apisol was destroyed. The Aggrenox had a delivery date of	02/14/2014

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	Based on observation, interview, and record review, the facility failed to ensure medication located in the medication storage refrigerator was disposed of in a timely manner for 1 of 5 multi-dose vials of Aplisol reviewed and failed to ensure a bottle of medication had the opened date documented in 1 of 3 medication carts. Findings include: On 1/13/14 at 11:00 A.M., an observation of 3 medication storage rooms and 3 medication carts located on West, East 1 and East 2 halls was completed. 1. One opened multi-dose vial (10 doses per vial) of Aplisol (medication used to administer tuberculosis skin test) was located in the refrigerator on East Hall 2. The bottle's opening date was documented on the vial. The date documented was 11/18/13. The package insert for Aplisol, which is manufactured by JHP Pharmaceuticals LLC, was reviewed on 1/13/14 and read as follows: "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."		12/21/13 from the pharmacy. The bottle was dated as opened on 12/21/13 and used according to pharmacy guidelines. All residents in the facility have the potential to be effected by not disposing of medications timely or using appropriate open date documentation. The facility will provide education for all nurses regarding disposal of medications timely and appropriate open date documentation. Guidelines for medication expiration dates will be placed in the MAR books and in the medication rooms. (Attachment I) The Medication Room/ Refrigerator Storage Review QA tool (Attachment J) will be completed weekly by DON or designee for 4 weeks and monthly thereafter. Any necessary corrections will be made immediately. Results will be reviewed by the QA Committee and any trends identified will be addressed with appropriate staff.	

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	During an interview with RN #2 on 1/13/14 at 11:10 P.M., RN #2 indicated the vial of Aplisol should have the date the medication was opened documented on the bottle and the bottle of Aplisol should have been discarded 30 days after the date documented. 2. One bottle of Aggrenox 25 mg/200 mg (a medication used as blood thinner to prevent strokes) contained 10 capsules. The Aggrenox was located in the medication cart on East Hall 2. The Aggrenox container was lacking documentation as to when the container was opened. During an interview with RN #2 on 1/13/14 at 11:20 A.M., RN #2 indicated she did not know when the bottle of Aggrenox was opened. During an interview with the ADON on 1/13/13 at 11:52 A.M., the ADON provided a list of expiration dates for medications. The ADON indicated it was the facility's policy to follow the guidelines for expiration dates provided by the pharmacy. The ADON further indicated Aplisol should be disposed of 30 days after opening the vial and Aggrenox			

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	should be discarded 90 days after opening the container. 3.1-25(r)			
F000458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on record review, observation, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple residents' rooms and 100 sq ft in single occupancy rooms. This was evidenced in 14 of 43 resident rooms in the facility. Rooms 3, 5, 7, 9, 13, 17, 19, 21, 22, 23, 24, 25, 10, 16. Findings include: Facility documentation of room size certification, dated 9/28/11, and provided by the Administrator on 1/13/12 at 12:25 P.M., indicated the following room sizes of observed rooms: *1. Room #3 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident	F000458	The facility has requested a waiver for the rooms cited in the survey. The facility does not feel that the size of the rooms cited has any adverse affect on the residents in those rooms. CMS has granted the waiver in years past.	02/14/2014

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	*2. Room #5 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *3. Room #7 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *4. Room #9 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *5. Room #13 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *6. Room #17 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *7. Room #19 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *8. Room #21 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *9. Room #22 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *10. Room #23 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident			

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	*11. Room #24 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident *12. Room #25 2 beds 154.65 sq ft SNF/NF 77.32 sq ft per resident These room sizes were verified by the Administrator on 1/13/12 at 12:25 P.M., as well as the room sizes of two additional single occupancy rooms which were observed to have less than 100 sq ft as follows: *13. Room #10 1 bed 90.52 sq ft per resident *14. Room #16 1 bed 90.52 sq ft per resident 3.1-19(l)(2)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F000465	It is the practice of this facility to	02/14/2014

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	Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain the facility in a safe and sanitary condition in that 4 residents' rooms had scrapes and holes in the drywall, 1 resident's bathroom had wallpaper pulling away from the wall and a toilet tissue dispenser located in an unsafe position, and 2 residents' bathroom exhaust fans were not functioning. This had the potential to impact 13 residents residing on East Hall 1 and East Hall 2. Rooms 7, 9, 10, 16, 17,19, 21, 23, 25. Findings include: During the initial tour of the facility on 1/8/14 at 11:30 A.M., the following observations were made: 1. The drywall above the headboard of bed #2 in Room #7, as well as the drywall behind the recliner in Room #7, was damaged with scrapes and gouges. The bathroom exhaust fan in Room #7 was not functioning. 2. The drywall behind the recliner in Room #9 was damaged with scrapes and gouges. A 3 inch by 3 inch piece of drywall was missing		maintain the facility in a safe and sanitary condition. All residents have the potential to be effected by this practice. The facility will check each resident room and bathroom to ensure it is in safe and sanitary condition. Any room found to need repairs will be placed on a QA log and scheduled for repair. The facility has purchased a new exhaust fan for all the bathrooms on East Wing. Room 7 had the drywall repaired above the headboard of bed 2 and behind the recliner. Room 7 had the exhaust fan replaced. Room 9 had areas of drywall repaired. Room 10 had the area behind the cove base cleaned and the cove base secured. The hole in the ceiling was repaired. Room 17 had the drywall repaired. The bathroom fan serving rooms 19 & 21 was replaced. The drawer pulls on the resident's dresser in room 17 were replaced. The bathroom between rooms 23 & 25 had the wall paper removed and was painted and the toilet paper dispenser was moved. The resident in room 25 had a new cushion placed in her chair. The facility will inspect resident rooms monthly for 6 months, then atleast quarterly thereafter (Attachment K). The maintenance supervisor or designee will be responsible to complete. Any problems noted will be corrected immediately or placed on a QA log to be repaired /addressed. Results will be	

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	next to the window frame in Room #9. 3. A 12 inch piece of cove base, which was located between the room entrance and the bathroom door, was detached from the wall surface, exposing dirt and debris in Room #10. A 2 inch diameter hole was observed in the ceiling above the resident's recliner in Room #10. 4. Damaged drywall (including multiple holes, scrapes and gouges) was observed on the wall next to the bathroom door in Room #17. 5. The bathroom fan, which served residents in both Rooms #19 and #21, was not functioning. 6. The drawer pulls were missing on the bottom drawer of the resident's chest of drawers in Room #16. 7. The toilet paper dispenser in the bathroom, which served the residents in Rooms #23 and #25, was located unsafely because its position obstructed the use of the right side arm rest when sitting to use the toilet. The wallpaper border around the ceiling and the door frame was detached and falling away in the bathroom which served		reviewed by the QA Committee and any trends identified will be addressed with appropriate staff.	

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	the residents in Rooms #23 and #25. 8. On 1/8/14, 1/9/14, and 1/13/14, a pillowcase (half of which was covered with red and brown stains) was observed in the recliner belonging to Resident #58 in Room #25. During an interview with the Maintenance Supervisor (MS) on 1/13/14 at 12:30 P.M., the MS indicated that all residents' rooms were inspected and assessed every three months for repair and maintenance needs. The MS indicated that the conditions outlined above were overlooked. During an interview with CNA #12 on 1/13/14 at 1:00 P.M., CNA #12 (when asked about the stained pillowcase belonging to Resident #58 in Room #25)indicated that the CNAs were responsible for replacing soiled, stained or dirty linens. 3.1-19(f)			
F009999				

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	3.1-28 Staff treatment of residents (c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. This rule not met as evidenced by: Based on interview and record review, the facility failed to report a hip fracture of an unknown cause to the state agency for 1 of 3 residents reviewed for falls. Resident #55 Findings include: Resident #55's clinical record was reviewed on 1/10/14 at 9:10 A.M. The clinical record indicated from September 2013 thru January 15, 2014, falls had been documented on 9/3/13, 9/25/13, 11/2/13, 12/24/13, and 12/31/13.	F009999	Resident #55 continues to reside in the facility and continues her routine activities. Any resident with an injury of unknown origin has the potential to be effected. The facility has reviewed all resident occurrence reports and has found no other injuries with unknown origin. The facility will educate nursing staff on investigating and reporting an injury of unknown origin per the Incident/Accident Policy and Procedure and Reporting to ISDH Policy (Attachments L,M). The facility will utilize the 24 Hour Condition Report Review QA Tool (Attachment N) daily for 30 days, weekly for 4 weeks and then monthly thereafter. The DON or designee will complete this tool and any problems will be corrected immediately. Results will be reviewed by the QA Committee and any trends identified will be addressed with appropriate staff.	02/14/2014

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	On 1/15/14 at 9:30 A.M., during interview with the Assistant Director of Nursing (ADON), she indicated an x-ray on 10/7/13, indicated Resident #55 had a left hip fracture. She indicated documentation was lacking of a fall between the 9/25/13 and the 11/2/13 fall. On 1/15/14 at 9:40 A.M., during interview with the ADON, an x-ray report dated 10/7/13 was reviewed. The x-ray indicated, the reason for x-ray was "...pain in left hip..." "...Findings: there is a partially impacted subcapital fracture of the left hip Comment: fracture left hip." The ADON indicated at that time the facility did not investigate the left hip fracture. On 1/15/14 at 11:35 A.M., during interview with the Administrator, she indicated she had not reported the 10/7/13 hip fracture to the state agency. She indicated she thought the fracture was from the 9/25/13 fall (12 day period between fall and fracture).			