STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00376587. Complaint IN00376587-Substantiated. Federal/State deficiencies related to the allegation is F676. Unrelated deficiencies are cited at F689. Survey dates: September 26, 27 and 28, 2022 Facility number: 000140 Provider number: 155235 AIM number: 100266960 Census bed type: SNF: 32 SNF/NF: 52 Total: 84 Census payor type: Medicare: 11 Medicaid: 51 Other: 22 Total: 84 These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed October 10, 2022.	F 0000		
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on interview and record review, the facility failed to ensure residents were given showers according to the scheduled shower days and times and as per the residents' preference for 3 of 3 residents reviewed for Activities of Daily Living (ADLs). (Residents C, D, and E)	F 0676	F-676 Activities of Daily Living (ADLs) Mntn Abilities It is the policy of Miller's Merry Manor to assist residents with showers based on their preference	10/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: 1. During an interview, on 9/28/22 at 4:13 p.m., Resident C indicated she had not had her showers as she preferred them or was supposed to have them. She was lucky if she got a shower every other week. The last time she can remember getting a shower was 9/18/22. She did not get a shower this past Saturday (9/22/22) because there was no hot water, so she refused to get her shower in cold water. Her shower days were supposed to be every Tuesday and Saturday on the evening shift. She usually got her shower between 2:00 p.m., and 5:00 p.m., so if she did not get her shower by 7:00 p.m., then she knew she was not getting it. Once in awhile, the CNAs would ask her if she wanted a bed bath in place of her shower, if they could not get her shower completed, but not very often. She did not even get her nightgown changed daily and all she wore was nightgowns. The shower schedule was reviewed and Resident C's showers were scheduled for every Tuesday and Saturday evening. The month of concern was March 1, 2022 through April 1, 2022. The following days were the days Resident C received her showers during that time period. 3/1/22 at 7:51 p.m. 3/5/22 at 2:45 p.m. 3/8/22 at 5:32 p.m. 3/15/22 at 3:19 p.m. 3/29/22 at 7:40 p.m. The days Resident C did not get a shower included, but were not limited to, the following dates:		of frequency. 1. Immediate action to correct was an audit was completed of showers and documentation with no current concerns from any residents. 2. All residents have the potential to be affected by the same deficient practice. No current residents have been affected. 3. To ensure that the deficient practice does not recur all nursing staff will be in-serviced on the facility shower schedule, which is based off of resident preference, and documentation in medical record when task completed or declined. In-service will include review of the policy titled, Point of Care Documentation & Legends, (Attachment A). 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Complaint Survey 9-28-22 POC (Attachment B). This tool will be completed daily (M-F) for 4 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3/12/22 3/19/22 3/22/22 3/26/22 During an interview, on 9/28/22 at 11:45 a.m., the Director of Nursing (DON) discussed showers and indicated all the showers if given would be documented on the shower/bath report. She would check and see if the resident had any refusals of showers in the timeframe being questioned. During an interview, on 9/28/22 at 4:44 p.m., the DON indicated she could not find any other shower documentation for the resident. She could not find where she had refused a shower during that time frame. 2. During an interview on 9/26/22 at 4:16 p.m., Resident D indicated she was not given the amount of showers she was suppose to have which was two a week. The shower schedule was reviewed and Resident D's showers were scheduled for every Wednesday and Saturday evening. The month of concern was March 1, 2022 through April 1, 2022. The following days were the days Resident D received her showers during that time period. 3/3/22 at 4:15 p.m. 3/7/22 at 9:33 p.m. 3/21/22 at 3:21 p.m. 3/31/22 at 1:19 p.m. The days Resident D did not get a shower included, but were not limited to, the following dates:		audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 10-24-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3/2/22 3/5/22 3/9/22 3/12/22 3/16/22 3/19/22 3/23/22 3/26/22 3/30/22 During an interview, on 9/28/22 at 4:44 p.m., the DON indicated she could not find any other shower documentation for the resident. She could not find where she had refused a shower during that time frame. 3. During an observation of Resident E, on 9/28/22 at 4:00 p.m., Resident E was unable to indicate if she received her showers per her preference or not. The shower schedule was reviewed and Resident E's showers were scheduled for every Sunday and Wednesday on dayshift. The month of concern was March 1, 2022 through April 1, 2022. The following days were the days Resident C received her showers during that time period. 3/2/22 at 12:14 p.m. 3/7/22 at 7:44 a.m. 3/9/22 at 12:07 p.m. 3/13/22 at 1:59 p.m. 3/23/22 at 9:53 p.m. The days Resident E did not get a shower included, but were not limited to, the following dates: 3/6/22 3/8/22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3/16/22 3/20/22 3/27/22 3/29/22 During an interview, on 9/28/22 at 4:44 p.m., the DON indicated she could not find any other shower documentation for the resident. She could not find where she had refused a shower during that time frame. This Federal tag relates to Complaint IN00376587. 3.1-38(b)(2)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents' care plans and transfer policies and procedures were followed to ensure residents were transferred from one surface to another surface safely for 2 of 3 residents reviewed for accidents. (Residents E and B) Resident E sustained a fractured left fibula and tibia bones with a 3 cm (centimeter) by 2 cm laceration to the top of her left shin area and Resident B sustained a fractured left tibia shaft bone Findings include:	F 0689	F-689 Free of Accident Hazards/Supervision/Devices It is the policy of Miller's Merry Manor to provide adequate assistance with transfers based on their plan of care. 1. Immediate action to correct was to ensure residents identified plans of care was correct with transfer needs required.	10/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1. A document, titled "Indiana State Department of Health Survey Report System," dated 9/27/22 at 12:30 p.m., indicated on 9/14/22 at 10:01 a.m., CNA 3 reported to the nurse caring for Resident E during a transfer from the resident's wheelchair to the bed using the Hoyer lift she heard a "cracking" noise. After the CNA laid the resident in the bed, she observed blood on the resident's left lower leg. Upon assessment by the nurse, a 3 cm (centimeter) by 2 cm laceration of the left lower leg was observed. An X-ray of the lower left leg was completed and the result indicated Resident E had an acute fibula and tibia fracture. After further investigation into the incident, CNA 3 reported Resident E got her left leg caught on the footboard during the transfer with the Hoyer lift. She was admitted to the hospital and was readmitted back to the facility on 9/17/22 after she had a surgical repair of her fractured fibula and tibia. Resident E's record was reviewed on 9/27/22 at 1:00 p.m. Diagnoses included, but were not limited to, unspecified fracture of the shaft of the left fibula and tibia (9/16/22), Femoral neck fracture (12/1/20), muscle weakness, polyneuropathy and diabetes mellitus type 2. On 6/14/22, a quarterly Minimum Data Set (MDS) assessment indicated her BIMS (Brief Interview Mental Status) was moderately cognitively impaired. She required extensive assistance (the resident was involved in the activity and staff provide weight bearing support) with a two person physical assist for transfers (how a resident moves between surfaces to and from bed, chair, wheelchair and standing position, but excludes to and from the toilet).		2. All residents have the potential to be affected by the same deficient practice. No other residents were affected. 3. To ensure that the deficient practice does not recur all nursing staff will be in-serviced on the process for identifying assistance required for transfers. The facility process for communicating this information to the staff is through the plan of care with transfer needs located on the CNA assignment sheet. Prior to transferring a resident from one surface to another surface staff should refer to the CNA sheet to know the level of assistance required including up to use of a mechanical lift. Staff will also be in-serviced on the policy titled, Joerns HOYER Stature lift policy (Attachment D). Moving forward, all nursing staff able to use the mechanical lift will be trained on use of the lift prior to using it. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Complaint Survey 9-28-22 POC (Attachment B). This tool will be completed on at least 5 randomly selected staff daily (M-F) for 4 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident E had a care plan, which addressed the problem she required extensive assistance with transfers (Initiated 3/10/2017). Interventions included, but were not limited to, provide assistance with sit to stand, surface to surface and balance support (Initiated 3/10/2017) and see Nurse Aide assignment sheet for details on transfer assist needed (Initiated 12/09/2021). Resident E had a care plan, which addressed the problem she required extensive assistance with transfers (Initiated 3/10/2017). Interventions included, but were not limited to, mechanical lift (Initiated 3/21/2001). A document, titled "CNA POCKET SHEETS" updated on 8/10/22 was provided by the Director of Nursing (DON) on 9/27/22 at 9:30 a.m. At that time, the DON indicated the CNAs were using that sheet to provide care for Resident E until she broke her left fibula and tibia bones, then her CNA assignment sheet was updated to include her new plan of care for the fracture of the left fibula and tibia bones. The sheet indicated Resident E was a maximum assist for ADL's and required a mechanical lift for transfers. A document, titled "Nursing-Occurrence Initial Assessment," dated 9/14/22, indicated the date and time of the occurrence was 9/14/22 at 10:00 a.m. CNA 3 reported during a transfer via Hoyer lift, she heard a "snap" noise and noticed blood dripping from the resident's left lower leg. The resident's shin area had a 3 cm by 2 cm laceration with active bleeding and the area was slightly swollen with bruising noted. The resident was not sent to the hospital for an evaluation or treatment. The wound was treated at the facility. The resident's physician was notified and a Stat (urgent) X-ray of the left lower leg was ordered.		and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. . 5. All systemic changes will be completed by 10-24-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A document, titled "Facility-Post Occurrence IDT and fall risk Assessment," dated 9/22/22, indicated on 9/14/22 at 10:00 a.m., CNA 3 reported to the nurse while transferring Resident E from the wheelchair to the bed using a Hoyer lift, she heard a "snap" noise and noticed blood dripping from the resident's left lower leg. When the nurse assessed the resident's left shin she observed a 3 cm by 2 cm laceration with active bleeding. The area had already started to swell. The injury to Resident E's left lower leg consisted of a laceration and a fracture of her left fibula and tibia. The root cause of this incident was Resident E's left leg got caught on the footboard of her bed while she was being lifted with the Hoyer lift so she could be laid down. The resident's progress notes were reviewed. There was no progress note located in the resident's record dated for 9/14/22, to indicate what occurred at the time of the Hoyer lift incident. There was an entry documented in the progress notes, dated 9/14/22, indicating she had an X-ray completed on 9/14/22, which indicated she had a fracture to her left lower leg. She was sent to the hospital and admitted for a surgical repair of the fracture. A document, titled "History and Physical Reports," dated 9/16/22 at 9:10 a.m., indicated Resident E was taken to the Emergency Room for a fibula/tibia fracture after her left leg hit the Hoyer lift while being transferred from her wheelchair to her bed. During an interview, on 9/27/22 at 1:58 p.m., CNA 5 indicated the Hoyer lift used on Resident E was taken off the floor. The DON took the Hoyer lift out of service, so no one else would use it and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	something else happen like it did with Resident E. A new electrical lift was ordered to replace that lift. During an interview, on 9/27/22 at 3:42 p.m., RPT 7 (Registered Physical Therapist) indicated minimal assistance was one person assist. The resident did 75% of the work and the staff member did 25% of the work. Resident E's standing goal was discontinued because she was transferred by Hoyer lift. Her current level of assistance was substantial/maximal assistance, which required two person physical assistance to transfer the resident. The staff did 75% or more of the work and the resident did 25% or less of the work. He indicated after the incident with CNA 3 and the Hoyer lift transfer of Resident E, the DON took the Hoyer lift off the floor, so it would not be used again by only one person completing a Hoyer lift transfer. During a phone interview, on 9/27/22 at 4:30 p.m., CNA 3 indicated she was doing a one person transfer with the Hoyer lift on Resident E when the incident occurred. She hooked the resident up to the Hoyer lift with the sling, then she tried to hold onto the resident's legs while maneuvering the Hoyer lift over to the bed to get the resident into a position to lie her down on the bed. Once she got the Hoyer lift to the bed, she had to move her bottom over the bed into the proper position, while manually sitting her up with the four point cradle. The Hoyer lift she used did not have the buttons on the four point cradle to electronically raise and lower the cradle, so she had to manually raise and lower the cradle to sit the resident up or lay her down. As she was moving the resident's bottom onto the bed she heard a "crack," as her feet got caught on the foot board of the bed. Prior to lowering her over the bed, she was sitting up in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the four point cradle like a chair with her legs dangling straight down. CNA 3 indicated the Hoyer lift machine was too hard to maneuver with one person while watching the residents' legs and feet to ensure they were not injured. She did not feel comfortable completing a Hoyer lift transfer by herself, but she did it anyway because she had a hard time finding staff members who would assist her with the Hoyer lift transfers. The staff on the third floor told her she was capable of completing the Hoyer lift transfer by herself with the Hoyer lift machines they had now, so they would not help her. The third floor hallway she worked on had a total of eight Hoyer lifts on it. She should have asked a staff member to assist her with the Hoyer lift transfer instead of doing it by herself. During an interview, on 9/28/22 at 4:13 p.m., with another resident who used a Hoyer lift, Resident C, she indicated she fractured her femur at home. At the facility, she was transferred to and from the wheelchair to bed and vice versa with the Hoyer lift and she was anxious the entire time she was being transferred. There were times, the staff used one person to transfer. She did not know what the aides based their decision off of as to whether they used one or two staff members to transfer her with the Hoyer lift. When two staff members transferred her, she felt better about the transfer because a staff member was maneuvering the Hoyer machine, while another staff member was guiding the four point cradle and watching her feet, head and neck. When one person transferred her, she felt like she was swinging in the air while being moved. The staff member running the Hoyer lift was in the back of the machine with the remote control, her legs were hanging straight down swinging in the air because the sling was swinging in the air, so her legs would hit the front			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of the Hoyer lift machine. Her legs have hit the front of the Hoyer machine more than once because the staff member cannot pay attention to the Hoyer lift and to the resident's feet and legs at the same time. During an interview, on 9/28/22 at 4:44 p.m., the Executive Director (ED) and DON were in attendance. The ED provided an untitled document, at that time, dated 11/25/2014, indicating the facility based their Hoyer Lift policy off this letter. She was not there at the time, but Corporate just sent her this letter and told her this was what they based the number of staff members needed to do a Hoyer lift off of. The DON indicated there was no formal assessment process for assessing residents to see if they were appropriate to be transferred with the lift. She indicated every morning, in the morning meeting, residents who have fallen, had a change of condition or a decline and could no longer sit to stand to transfer were discussed. The Manager of Rehab was in the meetings along with the DON, ADON and ED and they discussed those residents and decided together who should be transferred with the Hoyer lift versus manually transfer. The therapists did not assess the residents and tell nursing who did and did not fit the criteria to be transferred with a Hoyer lift. The DON indicated the CNAs who work for the facility through the agency should have been trained on how to use Hoyer lifts through the agency they were employed through. The facility did not check them off in any competency to ensure they were competent to use the Hoyer lift prior to them working on the units. They went through the facility orientation, but they did not do any specific skills check off. 2. A document, titled "Indiana State Department			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of Health Survey Report System," dated 9/16/22 at 1:32 p.m., indicated on 8/21/22 at 9:01 p.m., CNA 4 transferred Resident B to bed by a one person physical assist. The resident was transferred from her wheelchair to sit on the edge of the bed and as the CNA sat the resident on the bed, the resident complained she felt a "pop" in her left upper leg/hip region when she sat down. On 8/22/22, the resident was sent to the Emergency Room (ER) for evaluation and treatment of pain, low grade fever and increased confusion. The resident returned back to the facility the same day with no fracture. The next day 8/23/22, the resident informed staff her left foot, leg had gotten caught in the wheelchair during the transfer, on 8/21/22, and she complained of pain in the area. CNA 4 was interviewed and indicated she heard a "pop," but she was unaware the resident's foot had gotten caught during the transfer. A new order was obtained on 8/24/22, which indicated the resident had a left tibia shaft fracture. Resident B's record was reviewed on 9/26/22 at 4:00 p.m. Diagnoses included, but were not limited to, unspecified fracture of shaft of right fibula and tibia (5/2/22), unspecified fracture of shaft of left tibia (8/23/22), chronic pain syndrome, osteoarthritis, osteoporosis without a current pathological fracture, major depressive disorder and rheumatoid arthritis. The resident's quarterly MDS (Minimum Data Set) assessment, dated 6/29/22, indicated her BIMS (Brief Interview Mental Status) was a 12 out of 15, which indicated she was moderately cognitively impaired. She required extensive assistance (the resident was involved in the activity and staff provide weight bearing support) with a two person physical assist for transfers (how a resident moves between surfaces to and from bed,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	chair, wheelchair and standing position, but excludes to and from the toilet). Resident B had a care plan, which addressed the problem she was a fall risk due to having a history of a right ankle fracture, impaired balance with transfers with or without assistive devices, lower extremity weakness, osteoporosis, and required staff physical support to transfer (Initiated on 12/6/2016). Interventions included, but were not limited to, the following: gait belt for transfers (Initiated 5/27/2017). Resident B had a care plan, which addressed the problem she had a late loss of ADL's (Activity of Daily Living) and required assistance with transfers (Initiated 3/10/2017). Interventions included, but were not limited to, the following: provide assistance with sit to stand, surface to surface and balance support (Initiated 3/10/2017) and see Nurse Aide assignment sheet for details on transfer assist needed (Initiated 12/9/2021). A document, titled "CNA POCKET SHEETS," updated on 8/16/22 was provided by the DON on 9/27/22 at 3:30 p.m. At that time, the DON indicated the CNAs were using that sheet to provide care for Resident B until she broke her left tibia, then her CNA assignment sheet was updated to include her new plan of care for the left tibia fracture. The sheet indicated Resident B was a minimal assist x 1 (physical assist by one staff member) for ADL's (Activities of Daily Living) and transfers, non-weight bearing on the right leg, alert and oriented, she had a healing fracture to the right tibia/fibula area with a cast boot currently in place to the right leg. She had very fragile bones and skin. Staff needed to be careful not to bump her knee on the toilet while transferring her to the toilet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

A document, titled "Facility-Post Occurrence IDT [Interdisciplinary Team] & [and] fall risk Assessment," dated 8/22/22 at 10:59 a.m., indicated on 8/21/22 at 9:00 p.m., Resident B sat down on the side of the bed, she felt something "pop" to the left leg. Her pain rating was an eight out of ten (zero was no pain and ten was the worst pain she would ever experience). LPN 13 called the physician and obtained new orders for X-rays of her left leg for the next morning (8/22/22). The resident sustained a fractured left tibia shaft bone. The root cause of the injury was she had a diagnosis of osteoporosis. She required extensive assistance with any transfers. She recently became full weight bearing after a fracture to her right leg. She had been weaker and not as mobile with transfers, since she had the fracture to her right leg. The resident indicated her left leg was caught on the wheelchair during the transfer, which caused the "pop" sound and pain to occur.

An X-ray report of the left ankle, dated 8/23/22, was ordered and completed for complaints of pain to the left leg and bruising around the left ankle. The X-ray results indicated Resident B had a nondisplaced acute distal tibia shaft fracture.

The progress notes were reviewed, which included, but were not limited to, the following notes:

On 8/21/22 at 9:30 p.m., a staff member notified LPN 13 while she was transferring Resident B she heard a "pop" and the resident indicated she had "broke" her hip. LPN 13 assessed Resident B to discover she had a pain level of 7 out of 10, positive range of motion to her left lower extremity with a positive peripheral pulse in the left foot. She had a virtual phone visit with Physician 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	who ordered a left hip X-ray for the a.m. On 8/21/22 at 10:44 p.m., Physician 14 had a virtual phone visit with Resident B and assessed her primary complaint of extremity pain. He indicated the resident had a history of left hip pain. The physician indicated the CNA was transferring the resident and heard a "pop." There was no deformity to the left leg. The exam findings was by way of LPN 13 and video conference. The resident complained of left leg pain at a level 6 out of 10 with normal range of motion and no obvious deformities. She had pain to her left lower leg and the physician ordered the resident to stay at the facility and to get a left hip X-ray On 8/22/22 at 10:17 a.m., Resident B had a change of condition and a new order to send her to the ER for evaluation and treatment was obtained. On 8/23/22 at 6:45 a.m., Resident B's temp was elevated to 101.2 F (Fahrenheit), she had decreased oxygen saturation, so oxygen was applied with a nasal cannula tubing to which her oxygen saturation was increasing to 100% with oxygen on at six liters by nasal cannula. She was lethargic earlier in the morning when the nurse arrived on her shift, but since she received the oxygen she was more awake. She complained of discomfort to her left lower leg, but she was not able to define the area of pain at that time. On 8/23/22 at 9:44 a.m., the resident had an X-ray to her left ankle, left fibula/tibia to include the left knee due to pain to her left lower leg and fever. On 8/23/22 at 4:00 p.m., the Biotech X-ray tech was at the facility to complete X-rays of the resident's left ankle, left fibula/tibia, and left knee and the images were to be read STAT (urgent).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 8/23/22 at 4:50 p.m., the X-rays indicated Resident B had an acute distal tibia shaft fracture. The new orders included, but were not limited to, apply a boot to the left lower leg and keep it in place, non-weight bearing to left leg, and contact an orthopedic physician in the morning. On 8/23/22 at 5:00 p.m., the resident was notified of the new orders. The boot was applied to the left lower leg with the resident grimacing and yelling out with discomfort. During an interview, on 9/27/22 at 2:23 p.m., Resident B was alert and oriented to person, time and place. She indicated she was supposed to be a Hoyer lift transfer because of her fracture in her lower right leg, but she was stood up and was placed back to bed instead. She had fractured her right lower leg after falling out of a wheelchair a few months ago. She had just gotten her right leg healed up. During the time her right leg fracture was healing, she was transferred by a Hoyer lift. On 8/21/22, there were two aides in the room and one said to the other one, they only had to move her two feet, so why go to all the trouble of bringing the Hoyer lift in her room. An aide had gotten her up that morning with the Hoyer lift, so she had the sling under her already, all they had to do was hook her back up and place her in the bed. She asked the aides if they knew how to use the Hoyer lift and they said they did, but they did not need to use it with two of them in the room and as small as she was, they could just pick her up and put her into bed. They lifted her out of the wheelchair by putting one of their arms under one of her arms, then they took a hold of the back of her pants and stood her up. They did not use a gait belt. The aides started to turn her around when there was a very loud "Pop" sound and at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	that point, she yelled out because she got a very sharp pain and it felt like they broke her leg. One of them said "Did you hear that pop?" and she said "Yeah it was my leg and you broke it" and they said no we did not break it. As soon as they asked her what happened, she told them her foot got caught on something, then she heard a "pop" and instantly had pain in her lower left leg. During a phone interview, on 9/29/22 at 1:15 p.m., CNA 4 indicated she was the only one transferring Resident B the day the incident occurred (8/21/22). CNA 4 transferred the resident from her wheelchair to the bed. She picked her up with both her arms under the resident's arm pit areas and held onto the back of her pants. She did not use a gait belt. She transferred Resident B the same way she transferred all the other residents from a sitting position to a standing position, which was without a gait belt. The CNA who oriented her, for her one day of orientation she received, did not use a gait belt when she transferred residents. She did not know she had to use a gait belt when she transferred residents. She pivoted the resident around and sat her down on the edge of the bed. As she sat the resident down on the side of the bed, she heard a very loud "pop" noise and the resident yelled out "you broke my leg." CNA 4 indicated the resident's legs must have got caught on the wheelchair wheel. She left the resident sitting on the side of the bed and went to the doorway and called for QMA 16 to come to Resident B's room. QMA 16 and CNA 4 laid the resident down and CNA 4 observed QMA 16 ask the resident to point her left foot, she asked about her pain level, then she notified LPN 15. It was taking LPN 15, to long to come assess the resident, so she called the nurse on the first floor LPN 13 to come assess			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the resident and he came right away. LPN 13 had her point her toes and he asked her about her pain level. He did not think her leg was broke. CNA 4 indicated she was the only CNA transferring the resident and the resident may have thought two staff members transferred her into the bed because she called for QMA 16 to come look at the resident and she assisted CNA 4 to lay the resident down in bed. CNA 4 removed both foot pedals off the wheelchair prior to transferring her to the bed. She did not have a CNA pocket assignment sheet in her pocket that shift, which would have given her information on how the resident should have been transferred. The resident had been a Hoyer lift transfer two weeks prior because she had a boot on her right lower leg due to a fracture from a fall. She had just been changed to a sit to stand transfer of one assist in the computer, but she did not know what the assignment sheet indicated for her transfer method. CNA 4 indicated she should have used a gait belt instead of lifting and transferring the resident with the back of her pants. She should have had a second person to assist her with the transfer because of her being a new sit to stand lift transfer and she should have had a CNA pocket assignment sheet in her pocket. A current untitled document, dated 11/25/14, provided by the ED on 9/28/22 at 4:44 p.m., indicated "To Whom It May Concern: Joerns Healthcare does not make a formal recommendation on the number of caregivers required to use a mechanical lift and to transfer a patient. This allows maximum flexibility to determine the best practices for their patients and for their care staff. Joerns Healthcare recognizes that based on staff skill levels and individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	patient factors each lift situation has different requirements for safe patient transfer(s). With that said we recommend that each facility establish an internal policy for assessing all residents and for providing the proper equipment, training and staff for those patients who need to be transferred with a mechanical device such as Hoyer patient lift. Patients who have been appropriately assessed for the correct lift and sling may be transferred by one properly trained and certified care giver if in compliance with the specific facility policies." A current policy, titled "Joerns HOYER Stature lift policy," dated 11/10/16, provided by the SDC on 9/27/22 at 1:53 p.m., indicated "Policy: To safely transfer a resident from one surface to another via use of a mechanical lift. The HOYER Stature lift may safely be used by one staff member if the resident can follow instructions or is cooperative with the transfer. If in doubt, a second staff member should be present during the transfer. Responsible Staff: Nursing staff that have been trained and have demonstrated competency with use of the lift and slings...." A current policy, titled "Transfer from Chair to Bed," dated 3/18/22 and provided by the ED on 9/26/22, indicated "...To assist a resident from a chair to bed...Obtain additional assistance as necessary...If transferring the resident from a wheelchair...Place the residents feet firmly on the floor...If the resident cannot stand alone, apply the gait best [sic], grasp sides and assist resident to standing position, pivot turn and sit resident on edge of bed...If resident does not bear any weight, use the mechanical lift for transfer to prevent injury...Assist the resident to raise his or her legs on bed...." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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