STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 14, 15, 16 and 17, 2016 Facility number: 000020 Provider number: 155059 AIM number: 100288690 Census bed type: SNF/NF: 49 SNF: 4 Total: 53 Census payor type: Medicare: 10 Medicaid: 34 Other: 9 Total: 53 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Reviewed by 35984 on November 23, 2016.	F 0000	Please accept the following plan of correction as our credible Allegation of Compliance. We respectfully request your consideration for paper compliance for the deficiencies cited. Attachments A and B have been uploaded for submission with this plan of correction.	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure physician notification in regard to weight gain was completed for 1 of 5 residents reviewed for unnecessary medications (Resident #46).	F 0157	**F 157 Notify of Changes (Injury/Decline/Room, Etc.:** It is the policy of Miller's Merry Manor, Huntington to inform the resident, responsible party and the attending physician when there is a significant change in the resident's physical, mental, or psychosocial status in either life	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	Findings include: Review of Resident #46's clinical record began on 11/14/16 at 11:06 a.m. Diagnoses included, but were not limited to, dementia, atrial fibrillation, hypertension, and heart failure. There was a current physician's order, dated 12/31/15, for weekly weights to be taken on Wednesdays and update the physician for more than a five pound weight gain in one week. A review of her weekly weights indicated the following: 9/21/16 to 9/28/16, weight increased from 201.6 lbs (pounds) to 207.8 lbs (6.2 lbs difference). 9/9/16 to 9/14/16, weight increased from 200.4 lbs to 205.6 lbs (5.2 lbs difference). 8/17/16 to 8/24/16, weight increased from 201.6 lbs to 207.4 lbs (5.8 pound difference). 5/19/16 to 5/25/16, weight increased from 186.8 lbs to 196.8 lbs (10 lbs difference). 4/27/16 to 5/5/16, weight increased from 186.2 lbs to 192.4 lbs (6.2 lbs difference).		threatening conditions or clinical complications, including a need to alter treatment or discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. The physician of Resident #46 was notified of the resident's current weight status. The physician response was no change in treatment or plan of care. This has the potential to affect any resident in the building who has specific physician orders for weight monitoring and notification of weight changes. An audit of these residents will be completed to ensure that all orders are being followed appropriately. The facility notified the physician of the issues noted for Resident #46. Nursing staff will be in-serviced on the facility policy for notification of significant changes on or before 12-16-16. The facility unit Manger/Designee will be responsible to ensure that weights are reviewed weekly with those with specific orders for weight monitoring. The Unit Manger/Designee will then be responsible to ensure the attending physician was notified as needed of changes. The facility will utilize the QA tool	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	There was no physician notification in the clinical record of anyweight changes of greater than five pounds. On 11/17/16 at 1:48 p.m., the DON indicated there was no other information available regarding the physician being notified about the resident's weight gains. 3.1-5(a)(2)		"Nursing Services Audit" (Attachment A) to monitor daily changes in resident conditions to ensure that proper notification is completed. This tool will be completed by the DON/Designee on a daily basis x2 weeks, then weekly x4 weeks and then monthly thereafter. Any identified issues will be addressed immediately. Concerns/Issues will be logged on the Quality Improvement Summary Log (Attachment B) and reviewed/revised monthly in the facility Quality Improvement Meeting. Date of Compliance: 12-16-16	
F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interviews, the facility failed to ensure 12 residents requiring dining assistance in 2 of 3 dining rooms were served and assisted with meals in a dignified manner. Findings include: 1. The following observations were made in the dining room on the secured	F 0241	**F 241 Dignity and Respect of Individuality:** It is the policy of Miller's Merry Manor, Huntington to promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents #47,#35,#49,#37,#41,#17,#22,#9, #6,#4,#34,#48,#16 and #5 Have shown no adverse effects related	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	dementia unit on 11/14/16 between 12:20 p.m. - 12:52 p.m.: At 12:20 p.m., RN #22 was observed passing hot beverages to residents in the dining room, a CNA was bringing residents to the dining room and then leaving the dining room to bring in other residents. At 12:33 p.m., Resident #47 was observed licking the outside and trying to drink from an empty plastic cup. At 12:36 p.m., RN #22 placed a bowl of pudding in front of Resident #47 and Resident #35. Resident #47 dipped her plastic coffee mug, which had a hot beverage in it, into her pudding bowl and proceeded to lick the pudding from the outside of the coffee mug. She then eventually was able to drink from her coffee mug. Resident #35 made no attempt to feed herself. At 12:40 p.m., CNA #23 stood and tried to give Resident #37 a bite of pudding. The CNA then walked to a different table, stood and gave Resident #35 a bite of her pudding. Resident #47, who was seated next to Resident #35, was eating her chocolate pudding with her fingers. At 12:42 p.m., CNA #23 stood and fed		to this noted citation. This practice has the potential to affect all residents in the facility. All staff will be re-educated regarding dignity during mealtimes. This will be completed on or before 12-16-16. Reinforced to charge nurses/management staff the importance of monitoring during the dining process to ensure that resident needs are met and dignity is maintained at all times. A dietary staff member will assist on the Boulevard to ensure that all food and drinks are passed prior to leaving the unit. To ensure that dignity and respect of individuality of each resident is maintained the facility will utilize the QA tool “Nursing Services Audit” (Attachment A). This will be completed on a daily basis (variable mealtimes) by DON/Designee for 30 days, then 2x weekly for 4 weeks and weekly thereafter. Issues observed will be addressed immediately. Concerns will be logged on the Quality Improvement Summary Log (Attachment B) and will be reviewed/revised and followed through the monthly facility Quality Improvement Meeting. Date of Completion: 12-16-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	Resident #49 her pudding. The CNA then noticed Resident #47, walked over to her table and cued her to use her spoon to eat her pudding. At 12:43 p.m., CNA #23 had left the dining room, RN #22 was still passing beverages, and Resident #37 was awake with her beverages and pudding in front of her but was not being fed. At 12:45 p.m., the hot food cart was delivered to the secured dementia unit. At 12:45 p.m., Resident #49 received her meal tray. It was uncovered and left on the table in front of her. At 12:48 p.m., Resident #35 was served her meal tray. She briefly woke up, proceeded to feed herself broccoli casserole with her fingers and then fell back asleep. At 12:49 p.m., Resident #37, who was seated beside Resident #49 received her meal tray. It was placed on the table in front of her. At 12:50 p.m., CNA #23 sat down and fed Resident #49 one bite of food but then she got up and did not return to sit and assist Resident #49 and #37 with their meals until 12:52 p.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	At 12:52 p.m., RN #22 sat down to help Resident #35 with her meal. 2. The following was observed during the meal service on the secured dementia unit on 11/16/16 from 11:58 a.m. - 12:53 p.m.: From 11:58 a.m. - 12:13 p.m., CNA #24 and RN #22 were observed bringing residents into the secured unit dining room and placing clothing protectors on them. At 12:13 p.m., RN #22 started passing hot beverages and CNA #24 started passing cold beverages. At 12:22 p.m., RN #22 stood and gave Resident #37 a drink. After 3 minutes she sat down and continued to assist Resident #37 with her beverages. At 12:32 p.m., the hot food cart was delivered. From 12:36 p.m. - 12:38 p.m., the hot meals were delivered to all 9 residents who were in the dining room. At 12:38 p.m., CNA #24 sat down to feed Resident #37. However, she noticed another resident across the table needed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	assistance cutting up her food, she stood up and left Resident #37 without feeding her. While CNA #24 was assisting to cut up the food for another resident RN #22 directed her to get the salad and desserts from the refrigerator and pass them to the resident. CNA #24 then proceeded to pass salads and desserts from 12:40 p.m. - 12:45 p.m. At 12:45 p.m, CNA #24 sat back down to assist Resident #37 with her meal. The facility policy and procedure, titled ".10 Feeding Dependent Resident Procedure," dated 03/01/2001, did not include any instructions regarding sitting at eye level to feed dependent residents or feeding them their meal without stopping for extended periods of time. 3. During a dining observation of the assistive dining room, beginning on 11/16/16 at 8:28 a.m., the following was observed: CNA #59 indicated to CNA #57, who was half way across the room, to make sure Resident #17 had "double protein" for his meal, as she adjusted his chair without speaking to him. CNA #59 then asked BNA (basic nursing assistant) #56, who was on the other side of the dining room, if she had ever "fed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	them before", indicating to Residents #22 and #9. She indicated she had not. CNA #59 stated "today's the day you learn." CNA #57 stood over Residents #6 and #17, alternately offering them something to drink. While CNA #59 and BNA #56 were assisting Residents #22, #4, and #34, Resident #9 was eating hot cereal with a spoon. She was dripping some of it onto her clothing protector while bringing the spoon to her mouth. CNA #59 stopped CNA #57 as she walked by and asked her to get a plate guard. She then indicated to BNA #56 that they sometimes let her feed herself, but she made a mess, like she was doing then. She did not speak to the resident. The two staff members then began discussing what Resident #22 would or would not eat. Neither of them spoke to her. Resident #4 then asked if they were talking about her, to which CNA #59 indicated they were talking about Resident #22. 4. During a dining observation of the assistive dining room, beginning on 11/16/16 at 11:51 a.m., the following was observed: CNA #53 began passing drinks to the residents, placing them in front of them			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	on the tables. Activity Aide #54 was sitting next to Resident #9, who was seated in her Broda chair (a high-backed, reclining wheelchair) at a table. The activity aide asked CNA #53, who was now across the room, how the resident used her cups to drink from. RN #55 approached Resident #22's Geri-chair (a reclining wheelchair) from behind, and raised her to a sitting position without warning, indicating she was going to "tip ya up a bit" as she moved the chair. She offered her something to drink and then walked away. CNA #57 was standing over Resident #4, while offering her something to drink, then walked over to Resident #22 and offered her a drink. She then walked across the room and offered a drink to Resident #16 as she remained standing next to her wheelchair. BNA #56 was standing over Resident #6 while offering him something to drink. She then walked to the neighboring table and offered Resident #48 something to drink. She then walked back to the previous table and offered Resident #17 a drink. She indicated to CNA #57, who was standing across the table next to Resident #16, that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	all he did was "hold his spit in his mouth." CNA #57 walked across the room to Resident #5 and encouraged her to pick up one of her drinks. She then walked over to Resident #48 and stood next to him while offering him something to drink. At 12:17 p.m., Residents #48 and #41's meals were placed in front of them. Resident #48's plate was placed to the upper left of his table, just out of reach. Resident #41's utensils remained wrapped in her napkin. At 12:19 p.m., Residents #22, #9, #4, and #34 were served their meals. CNA #53 indicated to BNA #56 that Resident #9 was really alert that day, but wouldn't eat. Neither staff member spoke to the resident. At 12:22 p.m., CNA #58 began to assist Residents #48 and #41 with their meals. RN #55, CNA #53, and CNA #59 were discussing staffing issues as they assisted Residents #22, #9, #4, and #34. During an interview with BNA #62 on 11/17/16 at 10:43 a.m., she indicated she had been trained to sit with a resident to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	assist them during dining. She also indicated she had been trained to keep conversations focused on the residents. During an interview with CNA #58 on 11/17/16 at 10:50 a.m. she indicated she sat next to a resident when assisting them and tried to have a conversation with them while she was sitting with them. 3.1-3(t)			
F 0282 SS=D Bldg. 00	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 observation, interview, and record review, the facility failed to ensure careplan interventions were followed for fall prevention for 1 of 2 residents reviewed for accidents. (Resident #36) Findings include: 1. On 11/15/16 at 9:30 a.m., during the initial tour of the facility, Resident #36 was observed in his wheelchair near the nurse's station. He had a bruise under his right eye. On 11/17/16 at 8:33 a.m., he was seated in his wheelchair in his room, facing his	F 0282	**F 282 Services by Qualified Person/Per Care Plan:** It is the policy of Miller's Merry Manor, Huntington that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. Resident #36 had no adverse effects related to this citation. All residents who are at risk for falls have the potential to be affected. Care plans for fall prevention will be reviewed to ensure that interventions are appropriate and being followed by the staff. The facility will re-educate all staff regarding fall prevention and following plan of care	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	bed. His call light sat in his recliner chair to his left, out of reach, approximately three feet away. On 11/17/16 at 8:43 a.m., he began reaching over toward the recliner, leaning over the left arm of the wheelchair. At 8:44 a.m., he was able to reach the call light and turned it on. At 8:47 a.m., the DON, who was walking down the hall, entered the resident's room to answer his call. On 11/17/16 at 8:48 a.m., the DON indicated she was aware he had been left alone in his wheelchair in his room, and was requesting to be assisted into his recliner. Review of the clinical record began on 11/14/16 at 10:57 a.m. Diagnoses included, but were not limited to, hypertension, gastrointestinal hemorrhage, peripheral vascular disease, and shortness of breath. A quarterly, 8/17/16, Minimum Data Set (MDS) assessment, indicated he was cognitively intact, required extensive assistance for ADLs and bed mobility, and required total assistance for transfers. The clinical record indicated he was found on the floor on 11/5/16 at 8 p.m.,		interventions on or before 12-16-16. All resident care sheets will be reviewed to ensure information for fall prevention is current and accurate. To ensure this does not re-occur the DON/Designee will complete the QA tool “Nursing Services Audit”. (Attachment A). This will be completed weekly x4 weeks and then monthly thereafter. Any identified issues will be addressed immediately and logged on the “Quality Improvement Summary Log” (Attachment B). This will be followed and reviewed/revised through the monthly facility Quality Improvement meeting. Date of Compliance: 12-16-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	after he had had fallen forward from his wheelchair while asleep, resulting in a laceration under his right eye and an abrasion above is left eyebrow. He was treated and released from the emergency department the following morning for a head injury. Review of a "Post-Occurrence IDT & fall risk Assessment", dated 11/7/16, indicated he would be assisted to his recliner or bed after meals to prevent further falls. A current fall risk care plan, last revised on 11/8/16, included, but were not limited to, the following interventions: call light in reach and place in recliner or bed after meals. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interviews, the facility failed to ensure the facility policy/guidelines were	F 0309	**F 309 Provide Care/Services for highest Well Being:** It is the policy of Miller's Merry Manor, Huntington, to provide the	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	followed regarding providing substantial food and/or drink after short acting insulin administration for 1 of 2 residents observed receiving short activity insulin. (Resident #67) Finding includes: 1. During an observation of a medication administration pass, conducted on 11/16/16 at 7:37 A.M. with LPN #20, 16 units of Humalog, a short acting insulin was administered subcutaneously to Resident #67 while she was in her bathroom receiving bathing and dressing assistance. The resident was also given approximately 3 ounces of a low calorie orange drink with oral medication. She was not given anything to eat at the time the insulin was administered. Resident #67 was observed again on 11/16/16 at 7:54 a.m., and she was still in the bathroom getting dressed. She had not received her breakfast tray or anything to eat. During an interview with LPN #20, on 11/16/16 at 8:08 a.m., she indicated she thought Resident #67 had been given a glass of "real" orange juice around 6:00 a.m. and the resident refused any routine blood sugar assessments. The nurse did not elaborate on why Resident #67 would		necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #67 suffered no adverse effects related to this citation. All residents receiving short acting insulin have the potential to be affected. The nurse involved was re-educated. All nurses will be re-educated on the effects of short acting insulin and the time frames in which this should be administered on or before 12-16-16. In the event that there is a delay in the resident receiving their meal within the recommended time frame, the nurse will provide an appropriate snack to the resident. To ensure that this does not re-occur, the DON/Designee will observe insulin administration to residents 2x weekly for eight weeks and then weekly for eight weeks and monthly thereafter utilizing the "Nursing Services Audit" (Attachment A). Any issues identified will be immediately addressed with the nurse. Identified issues will be logged on the Quality Improvement Summary Log (Attachment B) and reviewed/revised in the monthly facility Quality Improvement Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	have been given orange juice by the third shift around 6:00 a.m. LPN #20 indicated she was not sure if the orange drink Resident #67 had been given with her oral medications was sugar free or regular. During an interview with the Food Service Supervisor, completed on 11/16/16 at 8:15 a.m., she indicated the orange powdered drink used by the nursing staff for medication administration was a "low calorie" drink. The packaging was observed and indicated there was 7.5 grams of sugar in an 8 fluid ounces. On 11/16/16 at 8:20 a.m., Resident #67 was observed in her room dressed eating a bowl of chocolate pudding. She had still not received her breakfast tray. She indicated she was a little "shaky" so they brought her chocolate pudding. The facility policy titled, "Recommended Insulin Administration times," dated 04/12 and provided by the Director of Nursing on 11/17/16 at 10:25 a.m., included the following: "...Humalog Within 15 minutes of eating a meal." 3.1-37(a)		Date of Compliance: 12-16-16	
F 0329	483.25(l)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
SS=D Bldg. 00	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interviews, the facility failed to ensure there were adequate indications for continued use and monitoring for the use of a medication to treat a neurological diagnosis for 1 of 5 residents reviewed for unnecessary medications. (Resident # 49) Findings include: The clinical record for Resident #49 was reviewed on 11/17/16 at 9:46 a.m. her diagnoses, including but not limited to:	F 0329	**F 329: Unnecessary Medications:** It is the policy of Miller's Merry Manor, Huntington, that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, without adequate indication for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons.	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	dementia, diabetes, osteoarthritis, hyperlipidemia, major depressive disorder and hypertension. A diagnoses of pseudobulbar affect was added on 09/09/15. Resident #49 was observed, on 11/14/16 at 2:30 p.m., seated in her wheelchair in the lounge area. She was noted to be repeating nonsensical numbers and phrases. She briefly stopped when spoken to and tried to hold and kiss other staff's hands if she could get ahold of them. She then went back to her repetitive speech. Resident #49 was observed on 11/15/16 at 9:30 a.m., seated in her wheelchair in the lounge area of the secured dementia unit. She was noted to be repeating nonsensical numbers and phrases. At times, when spoken to, she grimaced and tried to grab and affectionately bring other's hands to her face. She then continued her verbalizations. On 11/17/16 at 11:00 a.m., Resident #49 was observed sleeping in her room in a recliner. She woke up, had a calm look on her face, and was verbalizing repetitive numbers and phrases. The current physician's orders for medications included the medication,		Resident #49: Medication regimen has been reviewed by Nurse Practitioner to ensure that resident is free from unnecessary medication. The Nurse Practitioner provided documentation regarding the use of the medication and the effect that has been noted with the administration of this medication. All residents who are prescribed Nudexta medications are at risk to be affected. These residents will be reviewed by the IDT and Behavior Team to ensure that proper Diagnosis and documentation is present to support the use of this medication. To ensure that this does not re-occur, the DON/Designee will complete the audit tool “Nursing Services Audit”. (Attachment A) This tool will be completed monthly ongoing. Any issues will be addressed immediately and logged on the Quality Improvement Summary Log. (Attachment B) The Quality Improvement Summary Log will be reviewed/revised and followed through the facility monthly Quality Improvement meeting. Date of Compliance: 12-16-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	Nuedexta (mood stabilizer) 20 - 10 mg one capsule twice a day for PBA (pseudobulbar affect), secondary to dementia,initially ordered on 09/09/15. The nursing progress notes, physician progress notes, and behavior assessments were reviewed from 08/01/15 - 09/09/15 and there was no documentation of continued, distressing inappropriate laughing and crying consistent with the pseudobulbar affect diagnosis. Review of the electronic Point of Care behavior tracking for the dementia unit, indicated Resident #49's behaviors were not being "tracked" on a daily basis. A nursing note, on 09/07/15 at 2:23 p.m., indicated the resident was not showing any signs or symptoms of distress and had not had any change in her daily routine. A care plan related to the resident's diagnosis of pseudobulbar affect secondary to dementia, initiated on 9/9/2015, had a goal for the resident to have no complications related to the diagnosis. Interventions included to administer the medication as ordered and update the physician and family as needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	During an interview with the DON on 11/17/2016 10:53 a.m., she indicated the psychiatric nurse practioner, who had originally ordered the mediation, probably had the documentation to support the use of the medication. No documentation was provided. During an interview with LPN #21, on 11/17/16 at 11:20 A.M., she indicated Resident #49 occasionally was aggressive with care and continuously verbalized and would cry and laugh sometimes as she verbalized. LPN #20 indicated the resident did not seem distressed as she verbalized. LPN #20 indicated the resident did not display any signs of PBA because she was receiving Nuedexta. During an interview with the Social Service Director (SSD), on 11/17/16 at 2:00 p.m., she indicated the resident was having laughing and occasional loud crying in the midst of her normal repetitive speech patterns but the behaviors were not documented. The nurse practioner had put her on the medication for PBA and the behaviors were better but not tracked and monitored. The SSD indicated the nurse practioner did not document much in the way of observed behaviors before ordering the medication. The SSD indicated the medication was effective			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	for Resident #49 as the frequency of her outburst of laughing and crying had lessened since she had started taking the medication. The SSD indicated the behaviors were not necessarily tracked on a daily basis for Resident #49 because she was not on a psychotropic medication. A copy of a professional article regarding the use of Nuedexta in the treatment of PBA was provided. The article discussed the benefits of treatment with Nuedexta for patients with PBA and indicated the benefits should be evaluated. 3.1-48(a)(3) 3.1-48(a)(4)			
F 0371 SS=D Bldg. 00	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 food was served in a sanitary manner for 17 residents dining in the main dining room during 2 of 2 dining observations. Findings include:	F 0371	**F 371: Food Procedure, Store/prepare/Serve-Sanitary :** It is the policy of Miller's Merry Manor, Huntington, that all food be prepared and served in a clean, sanitary and safe manner to conserve	12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	During a dining observation of the main dining room, on 11/14/16 at 11:55 a.m., a cart, holding a tray of bowls of chocolate pudding, sat near the door to the kitchen. The plastic wrap covering the bowls was partially pulled back, exposing portions of the pudding. The cart sat under the hand sanitizer dispenser. At 11:56 a.m., the Dietary Manager (DM) used the hand sanitizer dispenser, while the cart containing the puddings remained under the dispenser. CNA #51 pulled the plastic wrap back further, removing three bowls, and served them to three residents. Ten bowls of pudding remained on the cart, with four of them uncovered, and one partially uncovered. CNA #52 then sanitized her hands using the dispenser, reaching over the tray of pudding to reach the dispenser. CNA #51 removed two more puddings, indicating they were for hall trays. During a dining observation of the main dining room, on 11/16/16 at 11:56 a.m., a cart, holding a tray of bowls of cherry dessert and yellow pudding, sat near the door to the kitchen. The plastic wrap covering the bowls was partially pulled back, exposing portions of the desserts. The cart sat under the hand sanitizer dispenser.		maximum nutritive value, develop and enhance flavor, and be free of injurious organisms and substances. There was no evidence that any food was actually contaminated because of the noted citation and no residents have shown any adverse effects related to this noted citation. 17 residents who eat in the main dinning room had the potential to be affected. On 11/16/16 at 12:03 the Dietary Manger re-covered food and relocated cart out from under hand sanitizer dispenser. Those staff working in the dining room were immediately instructed not to place any carts under hand sanitizer dispenser. The facility will educate all staff regarding placement of food cart in dining room to ensure safe distribution of food on or before 12/16/16. To ensure the safe distribution of food, the facility will utilize the QA tool "Nursing Services Audit" (Attachment A). This will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT ST HUNTINGTON, IN 46750

(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
	Staff was serving plates of food and alternately offering desserts to residents, while intermittently sanitizing their hands. The desserts remained partially uncovered under the dispenser. On 11/16/16 at 12:03 p.m., the DM indicated she saw the desserts were partially uncovered while under the dispenser. Review of a policy, titled, " Food Preparation, Food Handling, and Service," dated 10/6/16, and provided by the DM on 11/17/16 at 10:59 a.m., indicated food would be, "...prepared and served in a clean, sanitary, and safe manner...and be free of injurious organisms and substances...." 3.1-21(i)(2)		completed on a daily basis (variable mealtimes) by DON/Designee for 30 days, then 2x weekly for 4 weeks and weekly thereafter. Issues observed will be addressed immediately. Concerns will be logged on the Quality Improvement Summary Log (Attachment B) and will be reviewed/revised and followed through the monthly facility Quality Improvement Meeting. Date of Compliance: 12-16-16	