STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. BUILDING 00 B. WING	12/18/2018

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

(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 the Investigation of Complaint IN00281332. Complaint IN00281332 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: December 17 and 18, 2018 Facility number: 000174 Provider number: 155274 AIM number: 100274810 Census Bed Type: SNF/NF: 44 SNF: 1 Total: 45 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 8 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 26, 2018.	F 0000		
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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to develop and implement interventions to manage a resident's falls, and failed to provide supervision for a resident resulting in a fall with a back fracture; and failed to utilize a mechanical lift per the plan of care, resulting in a fall with a right arm fracture, for 2 of 3 residents reviewed for falls, in a sample of 5. (Residents C and D) Findings include: 1. On 12/17/18 at 9:10 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident C had a history of multiple falls. The DON indicated Resident C was demented, and tried to get up by herself. Resident C was observed at that time sitting in a recliner in the resident lounge, asleep. The clinical record of Resident C was reviewed on 12/17/18 at 1:30 P.M. Diagnoses included, but were not limited to, dementia. A quarterly Minimum Data Set (MDS) assessment, dated 9/4/18, indicated Resident C had a severe memory deficit, and required extensive assist of two + persons for bed mobility, transfer, and walking. A test for balance indicated the resident was "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, walking, turning	F 0689	It is the policy of Millers Merry Manor of Rockport to ensure that all residents are supervised appropriately to maintain safety and highest level of function throughout their stay. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident C – The Interdisciplinary Health Care Team (IDT) has reviewed and revised her health care plan and nurse aide assignment sheet to include preventative fall interventions based upon her risk factors, fall history and root cause analysis of previous falls. Resident C has had no falls since 12/17/18. Resident D – Is no longer a resident. **How will you identify other residents having the potential to be affected by the same alleged deficient practice?** All residents that reside at this facility have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure that the alleged**	12/22/2018

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	around, moving on and off the toilet, and surface-to-surface transfer. An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 09/06/2018, 23:15 [11:15 P.M.], Location of occurrence: residents [sic] room [number], Fall with injury. This nurse and CNA heard loud crash from residents room upon entering room resident was laying on right side in floor between recliner and bedside table noted to be in socks without shoes and when resident asked what happened she states 'I don't know I think I slipped' upon assessment noted small knot to back of left side of head with icepack applied to head...Type of injury: Bruise/hematoma [raised bruise]...Focus: Fall Risk: I am at risk for falls due to my condition and risk factors. Intervention: Initiate 15 minute checks x 72 hours until IDT [interdisciplinary team] can evaluate." A "Post Occurrence Assessment," dated 9/7/18 at 2:12 P.M., indicated, "Root cause: Resident currently has UTI [urinary tract infection] with weakness and increased confusion. IDT recommendations: Non skid socks. Fall Risk Assess: Confusion/forgetfulness (intermittent or constant), Weakness, Uses assistive device for mobility, Frequently forgets to use assistive device for walking. Unsafe or improper footwear." An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 09/12/2018, 06:30 [A.M.], Location of occurrence: Resident's room...Resident found in floor near bathroom, sitting up with legs out in front of her. She stated 'I fell on my butt.' Resident denies hitting head, does c/o [complain of] pain in lower back and hips (this is chronic, and hard to say if this is new pain). No visible signs of injury noted upon assessment...Indicate level of pain: Hurts a Little		**deficient practice does not recur?** 1. An in-service for all nursing staff was held on 12/20/2018 and 12/21/2018 the following was reviewed: A.) Fall management policy and procedure B.) What is your role (as a staff member) to assist in the prevention of falls/fall intervention (information sheet) & hourly rounding tool C) Meaningful immediate interventions post fall D.) Occurrence investigation E.) Falls QA audit tool F.) Risk management/ documentation 2. Falls will be reviewed daily in morning meeting. This will include all incident reports, progress notes, and those reported to DON or administrator or listed on the 24 hour report since previous meeting. Root cause analysis will be completed and the care plan revised to indicate intervention/s put into place to prevent reoccurrence. This information will be communicated to all nursing staff and nurse aide assignment sheet updated to reflect any changes or additions. **How will the corrective be**	

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	More...2nd fall in a week. Resident continues to be weak... Intervention: Initiate 15 minute checks x 72 hours until IDT can evaluate." A "Change in Condition Evaluation," dated 9/12/18 at 10:31 A.M., indicated: "Abnormal vital signs, Falls, Food and/or fluid intake, Functional decline...This started on: 9/4/2018...General weakness, Decreased mobility, Fall...HR [heart rate] elevated / BP [blood pressure] decreased from baseline...Does the resident have pain? Yes...Bilateral hips and lower back...Recommendation of Primary Clinician(s): Send to ER for Eval [evaluation] and Treat." The resident was transferred to the hospital on 9/12/18 at 10:39 A.M. A hospital note, dated 9/12/18 at 11:37 P.M., indicated, "...presents with back pain after multiple falls at the nursing home. She was found to have an acute compression fracture...Patient has progressive dementia, likely Alzheimer's type. Her daughter reports that she has fallen may times in the last few months. Yesterday she was found on the floor near the bathroom...Assessment and Plan: Closed compression fracture of L1 lumbar vertebra [back]...Fall from ground level...." A "Post Occurrence Assessment," dated 9/13/18 at 2:51 P.M., indicated, "...no injuries noted at time of assessment upon further examination L1 fracture noted. Root cause: Confused resident not able to determine safety risk. IDT recommendations: Resident will be put on toileting program and will not be left alone in bathroom. Fall Risk Assess: History of fall(s) in past 30 days. Recurrent falls - 2 or more in past 30 days, Confusion/forgetfulness, Parkinson [sic] disease, Uses assistive device for mobility,		**monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?** The Director of Nursing and/or her designee will complete Quality Assurance Assessments regarding fall risk management weekly for 4 weeks and then monthly. Findings of this audit information will have corrections made immediately and results presented to the QAA team at the monthly meeting. If during the meeting, changes or a new plan of action is deemed necessary, this information will be implemented at that time and monitored weekly by the DON or her designee until resolved.	

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	Unsteady gait with or without assistive device, Slow small shuffling gait, Requires staff physical support to transfer." The resident returned from the hospital on 9/14/18. An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 09/22/2018, 20:00 [8:00 P.M.], Location of occurrence: Residents [sic] room. Fall with injury. Resident was yelling 'help me.' Upon entering residents room, resident was lying on the floor, toward the foot of the bed, on her back. This nurse did note blood drops on the floor beside her head. Resident stated that she was getting back in bed. Resident did have gripper socks on...Type of injury, Back of head, 1.3 cm [centimeter] skin tear...Fall Risk: I am at risk for falls due to my condition and risk factors. Intervention: Initiate 15 minute checks x 72 hours until IDT can evaluate." A "Post Occurrence Assessment," dated 9/24/18 at 12:43 P.M., indicated, "...Type of injury: abrasion to back of head. Root cause: transferring self unassisted. IDT recommendations: safety strips on floor in front of bed...Fall Risk Assess: Recurrent falls, Confusion/forgetfulness, Parkinson disease, Weakness, Poor vision or blindness, Uses assistive device for mobility, Unsteady gait with or without assistive device, Slow small shuffling gait." Nurses Notes included the following notations: 11/22/18 at 3:02 P.M.: "Up w/c [wheelchair] with assist...Alert with confusion...." 11/25/18 at 1:47 P.M.: "...Alert with confusion...Cont [continue] to refuse brace			

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	daily...." An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 12/05/2018, 05:30 [A.M.], Location of occurrence: Resident's room. CNA's entered room. Resident found lying on mat beside lowered bed on right shoulder lying on side. Resident voiced no urgent pain. After sitting upright stated that her right shoulder was a bit sore...right shoulder has 3 cm x 2 cm slightly reddened area...will obtain X-ray of right shoulder today. Spoke with Resident regarding importance of using call light to utilize staff assistance for transfers or needs to prevent further occurrences....Fall Risk: I am at risk for falls due to my condition and risk factors. Intervention: Initiate 15 minute checks x 72 hours until IDT can evaluate." Nurses Notes indicated the x-rays were negative for fractures. A "Post Occurrence Assessment," dated 12/5/18 at 9:12 A.M., indicated, "...Type of injury: 3 cm x 2 cm reddened area to right shoulder - monitor until healed or no longer reddened. Root cause: [Left blank] IDT recommendations: Environmental check - findings that bed is in lowest position will be adjusting bed to appropriate height level to prevent further incident...Fall Risk Assess: [Left blank]." An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 12/17/2018, 01:45 [A.M.], Location of occurrence: Resident's room. CNA [name] entered the room for a routine bed-check and found resident on the floor in front of her chair lying on her R [right] side. Denies pain. States she didn't hit her head...Resident was not wearing non-skid socks. Encouraged to use			

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	call light if she needs assistance. Call light is in reach....Fall Risk: I am at risk for falls due to my condition and risk factors. Intervention: Initiate 15 minute checks x 72 hours until IDT can evaluate." On 12/18/18 at 8:35 A.M., the DON was interviewed regarding Resident C's falls. She indicated Resident C had multiple interventions in place. She indicated the resident had fallen again during the night. The DON indicated she informed her staff that they "may have to do hourly checks on her instead of 2 hours." She indicated the staff does 15 minute checks until they come up with interventions. The clinical record of Resident C was again reviewed on 12/18/18 at 9:10 A.M. An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 12/18/2018, 02:40 [A.M.], Location of occurrence: Resident's room. Upon entering room, CNA's [sic] found Resident beside bed on top of blankets on knees sitting. Denied hitting head...Staff assisted resident to sitting position on bed...slight redness noted to bilat. [bilateral, or both] knees...States she wasn't sure why she was trying to get out of bed. Advised resident importance of use of call light to alert staff to help resident transfer or assist to restroom for safety reasons. Resident voiced understanding...Fall Risk: I am at risk for falls due to my condition and risk factors. Intervention: Initiate 15 minute checks x 72 hours until IDT can evaluate." A Resident Care Plan, initially dated 6/11/18 and updated 12/17/18, indicated, "Fall Risk: I am at risk for falls due to my condition and risk factors. History of falls. Confusion/forgetfulness.			

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	Weakness, Incontinence. Uses assistive device for mobility. Unsteady fait [sic] with or without assistive device. Frequently forgets to use assistive device for walking. Impaired balance with transfers with or without assistive device. Requires staff physical support to transfer at times." The Interventions included: "12/17/18 Safety strips in front of recliner. 9/12/18 Do not leave alone in the bathroom. Call light in reach. Explain use of it upon admission and reinforce as needed." 2. The closed clinical record of Resident D was reviewed on 12/17/18 at 10:35 A.M. Diagnoses included, but were not limited to, cerebral infarction (stroke) and flaccid hemiplegia [weakness of one side]. A Physician's order, initially dated 12/1/16 and on the November 2018 orders, indicated, "Resident to be transferred per mechanical lift for all transfers." A quarterly MDS assessment, dated 9/25/18, indicated Resident D had a severe memory impairment, and required extensive assist of two+ staff for bed mobility and toilet use. The resident was totally dependent on two+ staff for transfer, and did not walk. A test for balance indicated the resident was "Not steady, only able to stabilize with staff assistance" for surface-to-surface transfer. A Care Plan, initially dated 11/13/17 and updated for a target date of 2/25/19, indicated: "Late loss ADL [activities of daily living]: Transfers I need extensive assist with transfers due to Dx [diagnosis]: flacid [sic] hemiplegia, weakness...Use of assistive device for mobility, Mechanical Lift." The Interventions included: "Mechanical lift."			

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An "Occurrence Initial Assessment" indicated: "Date and time of occurrence, 11/24/2018, 2000 [8:00 P.M.], Location of occurrence: Resident's room [number]. 2 Aids [sic] we're [sic] getting resident up from chair to put in bed. Resident became combative and Aids sat her on floor. There is no obvious injury. Resident is complaining of right arm pain but frequently complains of right arm pain. No deformities noted to right arm...Further comments: Educate staff on appropriate lifting techniques...."

Nurses Notes included the following notations:

11/25/18 at 1:40 A.M.: "...at 12:15 while being checked on resident had a purple bruise on her right arm around her shoulder into her under arm, and some swelling in bruised area, [name of hospice] notified...hospice called back and said for her to get x-rayed in the morning."

11/25/18 at 11:05 A.M.: "Xray results received via fax, resulting, a displaced fracture through the surgical neck of humerus [upper arm]...."

A "Post Occurrence Assessment," dated 11/26/18 at 10:20 A.M., indicated, "...Type of injury: no injury was noted at time of incident report, but on follow up assessments right arm became warm and swollen and resident appeared to be experiencing pain...x-ray was completed...Root Cause: improper transfer of resident causing injury...IDT recommendations: suspension of all staff present during transfer, education of all CNA's on Gait belt transfers, mechanical lift skills check off, reading and understanding assignment sheets...."

On 12/17/18 at 1:15 P.M., the DON was interviewed. She indicated 1 CNA and 2 NAs

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	[non-certified assistants] were with Resident D on 11/25/18. She indicated a CNA and NA were holding her up, while they were trying to clean her. She indicated she heard the resident became combative, and so they lowered her to the floor. The DON indicated the resident was supposed to require a mechanical lift for any transfers, and that information was on the CNA assignment sheets. She indicated none of the CNAs or NAs had their assignment sheets on them. The DON indicated the staff were suspended, and she inserviced all staff on mechanical lifts and assignment sheets. On 12/18/18 at 9:40 A.M., the Administrator provided the current facility policy, "Fall Management Procedure," dated 4/13/16. The policy included: "Purpose: To assess all residents for risk factors that may contribute to falling and to provide planned interventions identified by the team as appropriate for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible...The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls, and/or injuries related to falls...." This Federal tag relates to Complaint IN00281332. 3.1-45(a)(2)			