

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
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NAME OF PROVIDER OR SUPPLIER MILLERS MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00200001.</p> <p>Complaint IN00200001 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-312, F-315, and F-323.</p> <p>Survey dates: May 31, 2016, June 1, 2, 3, 6, 7, & 8 2016.</p> <p>Facility number: 00018 Provider number: 155053 AIM number: 100273930</p> <p>Census bed type: SNF/NF: 52 SNF: 9 Residential: 18 Total: 79</p> <p>Census payor type: Medicare: 11 Medicaid: 52 Other: 16 Total: 79</p> <p>These deficiencies reflect State findings</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0272 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 13, 2016</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;</p>			

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	<p>Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review the facility failed to have an accurate Minimum Data Set (MDS) assessment for a resident's ability to eat for 1 of 3 residents who met the criteria for Activities Of Daily (ADL) (Resident #F).</p> <p>Finding include:</p> <p>Review of the record of Resident #F on 6/2/16 at 11:20 a.m., indicated the resident's diagnoses included, but were not limited to, traumatic arthropathy left shoulder, acute transverse myelitis disease of the central nervous system, osteoarthritis, hypertension, asthma and osteoarthritis.</p> <p>The Admission MDS assessment for Resident #F, dated 12/17/15, indicated the resident required limited assistance of one person to eat.</p>	F 0272	<p>It is the policy of Miller's Merry Manor of Rushville that the facility will conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Resident #F no longer remains in the facility. All residents with functional limitations such as limited mobility have the potential to be affected. Comprehensive assessments for all residents at risk to be affected will be reviewed to ensure accuracy of the assessment. Education will be provided to the MDS Coordinator to ensure accurate Minimum Data Set assessments for functional limitation in eating ability are completed appropriately. The DON/Designee will review all comprehensive assessments completed weekly for the next four weeks, then monthly for three months and then quarterly thereafter utilizing the tool "RAI</p>	06/30/2016

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	<p>The 14 day scheduled MDS assessment for Resident#F, dated 12/23/15, indicated the resident required extensive assistance of one person to eat.</p> <p>Interview with the Director Of Nursing (DON) on 6/6/16 at 10:45 a.m., when queried what had the facility put in place for Resident #E when he declined in his ability to feed himself, the DON indicated the resident had a rotator cuff repair when he was admitted and had always required assistance of staff to eat. The DON indicated the MDS coordinator who did the resident's assessment was no longer working at the facility. The DON indicated she thought the Admission MDS assessment was marked incorrectly and was going to look at the resident's ADL documentation.</p> <p>Interview with the DON on 6/7/16 at 10:11 a.m., indicated according to Resident #E's ADL documentation the resident always required extensive assistance with eating and he had not had a decline. The DON indicated the Admission MDS assessment was marked incorrectly for his ability to eat.</p> <p>3.1-31(a)</p>		<p>Review" tool to ensure functional limitation are coded correctly(Attachment A). Identified issues will be addressed immediately and logged onthe Quality Improvement Summary Log (Attachment B). The summary log will bereviewed and followed in the facility monthly Quality Assurance ImprovementMeeting to ensure ongoing compliance.</p>	

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, interview, and record review the facility to accurately monitor and assess bruising and a open lesion for 2 of 3 residents who met the criteria for non pressure skin conditions (Resident #E and Resident #D).</p> <p>Findings include:</p> <p>1.) During observation and interview with Resident #E on 5/31/16 at 11:56 a.m., indicated the resident a large purple and blue bruise on her right forearm. Resident #E indicated she was unsure how she acquired the bruise.</p> <p>Review of the record of Resident #E on 6/3/16 at 10:06 a.m., indicated the resident's diagnoses included, but were not limited to, acute kidney failure, hypertension, anxiety, Alzheimer's disease, osteoarthritis, anemia and</p>	F 0309	<p>It is the policy of Miller's Merry Manor of Rushville to 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.</p> <p>Incident reports completed for Resident #E and Resident #D and areas monitored per facility policy.</p> <p>All residents with non pressure skin conditions have the potential to be affected. Skin assessment to be completed on all residents to ensure any skin conditions have been identified.</p> <p>In service education provided to all nurses and direct care staff regarding skin issues.</p> <p>To ensure this does not reoccur the DON/Designee will complete the QA audit tool titled Non-Pressure Skin Areas (Attachment C) to ensure that all</p>	06/30/2016

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	<p>fibromyalgia.</p> <p>The skin assessment for Resident #E, dated 5/31/16 at 8:55 a.m., indicated no bruising.</p> <p>The skin assessment for Resident #E, dated 6/1/16 at 1:14 p.m., indicated no bruising.</p> <p>The skin assessment for Resident #E, dated 6/2/16 at 12:49 p.m., indicated no bruising.</p> <p>The skin assessment for Resident #E, dated 6/3/16 at 10:00 a.m., indicated no bruising.</p> <p>During observation on 6/3/16 at 11:47 a.m., Resident #E was sitting in the therapy room, the resident continued to have a blue bruise on her right forearm. The resident indicated the bruise was not painful.</p> <p>Interview with the Director Of Nursing (DON) on 6/3/16 at 1:40 p.m., indicated the nurses were responsible to do a head to toe skin assessment and document and monitor bruising. The DON indicated the facility then would attempt to investigate what caused the bruising and the root cause of the bruising. The DON indicated she was</p>		<p>new skin issues identified have been addressed according to facility policy and procedures. This tool will be completed daily for thirty days, weekly for four weeks, and then monthly thereafter. Nurses will be required to complete weekly skin alteration sheet. Any concerns will be addressed immediately and logged on the QA Problem Summary Log. The issue will be reviewed and addressed monthly in the facility Quality Assurance meetings.</p>		

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	<p>unable to find documentation for the bruise on Resident #E's right forearm, but would assess the resident at this time.</p> <p>The skin assessment for Resident #E, dated 6/3/16 at 2:00 p.m., indicated the resident had a bruising on her right forearm measuring 2.0 clinometers (cm) by 1.0 cm and a bruise on the right wrist measuring 1.0 cm by 0.5 cm.</p> <p>2.) During observation and interview with Resident #D on 5/31/16 at 2:01 p.m., indicated the resident had several bruises on his right forearm and a black and bloody abrasion on right side of his forehead. Resident #D indicated he bruised easy because of "old age" and the wound on the right side of his forehead had been there for a long time.</p> <p>The "non healing wound assessment" for Resident #D, dated 5/10/16 at 3:12 p.m., indicated the resident had a lesion on the right side of his temporal region near the front of his ear. The wound measured 4.0 cm by 4.0 cm by less than 0.1 cm deep. The wound was open, attached and irregular. The wound bed had granulation and was moist. There was slough and eschar. There was a moderate amount of serosanguinous drainage present. The area had been diagnosed as cancer. The resident was non-compliant with "not</p>			

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	<p>messing with area once scabbed over." The resident would pick the scab off causing the lesion to bleed. There was no further assessments documented of the wound or bruising after 5/10/16.</p> <p>The skin assessment for Resident #D, dated 5/27/16 at 9:05 p.m., indicated no bruising. The resident was receiving antibiotic ointment and dressing to temporal area above the right ear.</p> <p>During observation on 6/3/16 at 11:30 a.m., Resident #E had a dressing on the right side of his temple and five round dark purple bruises on his right forearm. The resident indicated he thinks the bruising came from his oxygen tubing wrapping around his arm.</p> <p>Interview with the DON on 6/3/16 at 1:35 p.m., indicated there was no assessments of the Resident #E's wound on the right side of his forehead after 5/10/16. The DON indicated the wound nurse did not monitor and assess the wound weekly because it was a non-healing wound. The DON indicated "no it was not careplanned not to assess the wound." The DON indicated she was unable to find any documentation of the resident's bruising.</p> <p>The skin assessment for Resident #E,</p>			

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	<p>dated 6/3/16 at 2:00 p.m., indicated the resident had a bruise on the right antecubital measuring 1.0 cm by 0.5 cm, a bruise on the right elbow measuring 2.1 cm by 1.0 cm, a bruise on the right upper arm measuring 1.5 cm by 1.0 cm and a bruise on the right upper arm measuring 3.0 cm by 1.0 cm. The resident indicated he was "old and his skin was fragile".</p> <p>The "wound and non-wound assessment" policy provided by the DON on 6/3/16 at 11:45 a.m., indicated "all wounds, as defined below, will be managed by the facility wound nurse." "Assessment findings will be documented". "Each week or more often if needed, the wound assessment will be completed to include: location, stage, current status, measurement, description, pain associated".</p> <p>The definitions of wounds included, but were not limited to, "lesions cancer/syphilis/herpes". "All non wound skin alterations will be managed by the licensed staff nurses." Bruises will be monitored for at least daily for 7 days for complications such as pain that may indicate need for further assessment."</p> <p>3.1-37(a)</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to ensure a resident received adequate bathing, providing her with a bed bath according to her bathing preference and schedule for 1 of 3 residents reviewed for Activity's of Daily Living (ADL) of 29 residents who met the criteria for ADL. (Resident #A)</p> <p>Findings include:</p> <p>An interview with Resident #A's daughter on 6/2/16 at 2:32 p.m., indicated her mother was not being bathed enough.</p> <p>Resident #A's record was reviewed on 6/3/16 at 10:37 a.m. Her diagnoses documented on her June 2016 physician's recapitulation orders included but were not limited to, dementia with behavioral disturbance, malaise ,and chronic obstructive pulmonary disease.</p> <p>Resident #A's admission Minimum Data Set (MDS) assessment dated 4/14/16,</p>	F 0312	<p>It is the policy of Miller's Merry Manor of Rushville to provide necessary services to our residents to maintain good nutrition, grooming, and personal and oral hygiene. Resident#A shower/bath schedule was reviewed. Staff re-educated on documentation of ADL care. All residents had the potential to be affected. All residents bath/shower documentation reviewed for 30 days. Review of shower schedule completed for all residents. Care plans updated as needed. All nursing staff re-inserviced on bath and shower documentation. To ensure this does not reoccur, the DON/Designee will complete the QA Audit tool ("Bathing and Showers" Attachment D). The tool will be completed daily for thirty days, then weekly for four weeks, and then monthly thereafter. Any concerns will be addressed immediately and logged on the ("QA Summary Log" Attachment B).The corrective actions will be monitored through the monthly</p>	06/30/2016

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	<p>indicated she was severely impaired for her cognitive daily decision making skills. She had impairment on 1 side of her lower body. She required limited assistance of 1 person for dressing and personal hygiene.</p> <p>Resident #A's preference for bathing documentation dated 4/11/16, indicated Resident #A preferred a bed bath.</p> <p>A review of Resident #A's "Shower/bath report" documentation indicated Resident #A had only received a.m., and p.m., care (includes oral care) from 5/11/16 through 5/30/16. She had not received a full bed bath according to her preference on her scheduled bath days during that time. No refusals were documented during that time.</p> <p>An interview with the Director of Nursing (DON) on 6/7/16 at 3:17 p.m., indicated Resident #A's scheduled bath days were Tuesday and Friday every week on day shift. She indicated "sometimes when the aides are documenting a.m., and p.m., care they are doing complete bed baths but are not documenting it correctly. The MDS Coordinator has been working with them on their charting."</p> <p>This federal tag relates to Complaint</p>		QA Meeting.				

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F 0315 SS=D Bldg. 00	<p>IN00200001.</p> <p>3.1-38(a)(A)(B)(C)(D)(E)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident who was incontinent of urine and had the ability to participate in bladder retraining with a restorative toileting program for 1 of 3 resident's reviewed for bladder incontinence. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 6/3/16 at 10:37 a.m. Her diagnoses documented on her June 2016 physician's</p>	F 0315	<p>It is the policy of Miller's Merry Manor, Rushville that based upon the resident's comprehensive assessment indicating bladder incontinence, a plan will be in place to restore as much normal bladder function as possible. If the resident is not able to participate in a toileting plan, there will be a plan in place to manage incontinence. Resident A now has a toileting plan in place. All resident's with incontinence have the potential to be affected. Review of the most recent bowel and bladder assessment will be completed on all incontinent residents to ensure that an</p>	06/30/2016

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	<p>recapitulation orders included but were not limited to, dementia with behavioral disturbance, malaise, and acute kidney failure.</p> <p>Resident #A's admission Minimum Data Set (MDS) assessment dated 4/14/16, indicated she was understood and had the ability to understand others. She was severely impaired for cognitive daily decision making skills. She required extensive assistance of 2 persons for toileting.</p> <p>A "Nursing-Supplemental Combo 3.0-for annual and sig (significant) change" assessment for Resident #A dated 4/14/16, indicated she was admitted to the facility on 4/7/16. Her "Bladder Continence and Toileting Ability Assessment" indicated she was occasionally incontinent. A possible contributing diagnoses was congestive heart failure. A possible contributing medication was the use of a diuretic. She had a voiding pattern completed on 4/12/16, and a pattern was detected. She was mentally and physically aware of the need to void and able to use the toilet. She was mentally and physically able to resist voiding for attempting a bladder retraining program. A toileting program was not being used to manage her urinary incontinence.</p>		<p>appropriate plan is in place to manage incontinence or restore bladder function. The plan of care will be updated as needed. Education will be provided to all direct care staff regarding toileting and incontinence management plans. Resident care sheets will indicate if resident on specific toileting plan. To ensure this does not recur, the MDS/Designee will complete the QA audit tool Bladder and Bowel Incontinence Review (Attachment E). This will be completed weekly x 4 weeks, monthly x 3 months and quarterly thereafter. Any issues identified will be addressed immediately and logged on the "Quality Improvement Summary Log" (Attachment B). This will be followed and reviewed in the facility monthly QA meeting.</p>	

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	<p>A restorative toileting program was not initiated for Resident #A until 6/2/16, following and interview with the MDS Coordinator.</p> <p>An interview with the MDS Coordinator on 6/2/16 at 10:50 a.m., indicated he had spoke with a therapy staff approximately 2 weeks prior and discussed what residents may benefit from a restorative program. He indicated Resident #A was not on any restorative programs but he planned to put her on a restorative toileting program.</p> <p>On 6/6/16 at 9:42 a.m., Resident #A was observed seated in a soft recliner in the TV room across from the nurses station. She asked "do you know where the restroom is?" RN #2 and RN #3 assisted Resident #A to the bathroom with the use of a gait belt. Resident #A ambulated to the bathroom adjoined to her bedroom and lowered her slacks and brief as she sat down on the toilet. Resident #A urinated in the toilet and cleaned herself with toilet paper before getting up. Resident #A had been pleasantly confused and had not recognized her own bedroom when she had exited the bathroom, and stated "I have a bedspread just like that." When Resident #A was finished in the bathroom she ambulated</p>			

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	<p>through her bedroom and back to the TV room assisted by RN #2 and RN #3 with the use of a gait belt and sat back down in the soft recliner.</p> <p>The "Bladder Rehabilitation Program" provided by the Administrator on 6/8/16 at 11:00 a.m., indicated the following: "Purpose: A. To promote continence through means of bladder retraining or individualized habit programs based on the resident's cognitive ability. B. To enhance continence and reduce the risk factors of incontinence related complications, by providing routine or scheduled intervals of toileting assistance. 2. Bladder assessment procedure: Complete the Bladder/Bowel assessment located in the EMR titled "Nursing Bladder and Bowel assessment (located in the combo and as a single assessment) within 5 days of admission and with each significant change or change in continence. A. Assessment includes the following: Current continence status. Mental status - to determine comprehension of toileting needs. Physical status - to determine physical limitations of needs related to toileting. Further assessment of possible contributing medications and diagnosis. B. The 3 day voiding pattern is to be initiated within 48 hrs (hours) of new admission on all incontinent residents</p>			

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F 0323 SS=G Bldg. 00	<p>and with significant changes to continence status to determine if any natural patterns can be determined. ...C. After completion of the assessment and the elimination patterns, determine if resident is a candidate for a formal bladder "retraining" program or a bladder "habit" training program. 3. Bladder Habit Training Program (routine assisted or prompted toileting). A. Determine if there is a pattern from the 3 day voiding assessment. B. If there is a pattern, develop the toileting program from this pattern. C. If there is not a determinable pattern, develop a plan to toilet the resident at regular intervals and prevent incontinence related complications. D. Update the care plan and CNA assignment sheet to include the plan..."</p> <p>This federal tag relates to Complaint IN00200001.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident</p>				

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	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to determine an appropriate root cause analysis, implement appropriate interventions, and ensure restorative rehabilitation services for ambulation and toileting and close supervision were provided for a resident who was a candidate for restorative programs and required close supervision when she continued to fall, resulting in sutures, skin tears, and bruising for 1 of 3 residents reviewed for accidents of 3 who met the criteria for accidents. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 6/3/16 at 10:37 a.m. Her diagnoses documented on her June 2016 physician's recapitulation orders included but were not limited to, dementia with behavioral disturbances, malaise, displaced intertrochanteric fracture of the right femur and initial encounter for closed fracture.</p> <p>A "Nursing-Occurrence Initial Assessment' for Resident #A indicated on 3/31/16 at 1:30 a.m., she had stood up</p>	F 0323	<p>It is the policy of Miller's Merry Manor, Rushville to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents. An informal dispute resolution has been requested for the deficiency cited in attached documentation Resident #A continues to reside in the facility. Care plan and fall risk factors reviewed and updated appropriately. All residents who are at risk for falls have the potential to be affected. All resident fall risks/care plans will be reviewed to ensure appropriate interventions are in place. All staff to be inserviced on falls/prevention. To ensure this does not reoccur, the DON/Designee will complete the QA audit tool titled "Fall Risk Management Review" (Attachment F) daily for thirty days, weekly for fourweeks, then monthly thereafter. Any identified issues will be immediately corrected and documented on facility QA Summary Log. Logs are reviewed during the monthly facility Quality Assurance meeting.</p>	06/30/2016	

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	<p>from a recliner in the resident's lounge and had fell on her right side. She had complained of right leg pain with movement and had been transferred to a hospital for evaluation and treatment.</p> <p>A "Nursing-Acute-Return from short there stay" for Resident #A indicated she had returned to the facility on 4/7/16 at 6:15 p.m., by ambulance from a hospital where she had a broken hip surgically repaired.</p> <p>A plan of care for Resident #A initiated 3/29/16, indicated she was a fall risk characterized by risk factors that included weakness, lack of safety awareness, medications, and a recent fall that resulted in a hip fracture. Her goal indicated her risk factors would be reduced in an attempt to avoid significant injury related to her falls.</p> <p>Resident #A's admission Minimum Data Set (MDS) assessment dated 4/14/16, indicated she was understood and had the ability to understand others. She was severely impaired for cognitive daily decision making skills. She required extensive assistance of 2 persons for transfers and toileting. She had not walked and utilized a wheelchair for mobility. She had impairment on 1 side of her lower body. She had occasional</p>			

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	<p>pain of 3 on a pain scale of 0 to 10. She had a fall with injury within 6 months of her admission. She had 1 fall since admission with no injury.</p> <p>A "Bladder Continence and Toileting Ability Assessment" documented on Resident #A's "Nursing-Supplemental Combo 3.0-for annual and sig (significant change" assessment dated 4/14/16 at 9:54 a.m., indicated she was occasionally incontinent. She had a voiding pattern completed on 4/12/16, and a pattern was detected. She was mentally and physically aware of the need to void and able to use the toilet. She was mentally and physically able to resist voiding for attempting a bladder retraining program. A toileting program was not being used to manage her urinary incontinence.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 4/14/16 at 9:30 p.m., she had got out of her recliner in her bedroom while it was reclined and landed on her buttock. Her alarm had been in place and working. No injury resulted from the fall.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 4/15/16 at 9:30 a.m. indicated the root cause of the fall on 4/14/16 at 9:30 p.m., was she had wanted to go to bed. The</p>			

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	<p>Interdisciplinary Team (IDT) recommendation was she would offered to go to bed around 9:00 p.m.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 4/24/16 at 8:30 p.m., she had attempted to transfer herself from her wheelchair to her bed and slid to the floor. She had been assisted to bed by staff. No injury resulted from the fall.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 4/25/16 at 9:48 a.m., indicated the root cause of the fall on 4/24/16 at 8:30 p.m., was she had attempted to transfer herself to bed. The IDT recommendation was she would be assisted to bed after supper.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 4/28/16 at 8:00 p.m., she had attempted to transfer herself from her wheelchair to her bed and had fallen to the floor bumping her right foot. She had complained of lower back discomfort. She had a skin tear that measured 1.0 centimeter (cm) by 2 cm on her right anterior foot with a small amount of bleeding. The area had been cleansed and op-site had been applied.</p> <p>A "Post Occurrence IDT & Fall Risk</p>			

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	<p>Assessment" for Resident #A dated 4/29/16 at 8:52 a.m., indicated the root cause of the fall on 4/28/16 at 8:00 p.m., was she had attempted to transfer herself to bed. She had been offered to go to bed after supper but had declined at that time. The IDT recommendation was she would be offered to get in her recliner or to go to bed after supper.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 4/29/16 at 1:30 p.m., she had attempted to transfer herself from her wheelchair to a lounge chair in the west wing lounge and fell. She had been assisted back to her wheelchair by staff. Neurological checks were initiated per facility protocol. No injury resulted from the fall.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/2/16 at 9:53 a.m., indicated the root cause of the fall on 4/29/16 at 1:30 p.m., was she had no safety awareness. The IDT recommendation was staff would check on her every 30 minutes.</p> <p>A "PT-Therapist Progress & Discharge Summary" for Resident # A dated 5/2/16, indicated she had received physical therapy for a diagnosis of difficulty in walking from 4/8/16 until 4/28/16. She</p>			

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	<p>had shown partial gains in her functional activity which required minimal assistance of 2 persons. She was discharged with a recommendation for the facility to continue providing functional assist of 2 persons.</p> <p>An "OT-Therapist Progress & Discharge Summary" for Resident #A dated 5/2/16, indicated she had received occupational therapy for a diagnosis of generalized muscle weakness from 4/8/16 until 4/28/16. She had shown gains in strength, standing balance and tolerance which allowed for improvement with her self care and mobility skills.</p> <p>A "Nursing-Occurrence Initial Assessment for Resident #A indicated on 5/4/16 at 2:50 a.m., she was in her bedroom and had attempted to take herself to the bathroom and fell on her buttock, resulting in a skin tear to her left elbow that measured 5 cm. The area had been cleansed and 3 steri-strips had been applied and then covered with a dressing. Staff had not heard her alarm sound and had heard her yelling for help. Neurological checks had been initiated.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/5/16 at 9:34 a.m., indicated the root cause of the fall on 5/4/16 at 2:50 a.m.,</p>			

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	<p>was she had to go to the bathroom in the middle of the night. She had been assisted to the bathroom an hour and half earlier. The IDT recommendation was the facility would do a urine dip.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 5/6/16 at 6:00 a.m., she had got out of bed on the opposite side of bed from her floor alarm. She had not had a bed alarm on her bed at that time. No injury resulted from the fall.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/9/16 at 9:40 a.m., indicated the root cause of the fall on 5/6/16 at 6:00 a.m., was she got up unassisted. The IDT recommendation was she would have a floor alarm on the side of her bed and a pad alarm under her in bed. Staff would continue to check on her every 30 minutes.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 5/9/16 at 10:00 a.m., she had been sitting in her wheelchair in the east wing nurses station attempting to get out of her chair to look for her daughter. She had calmed down. After a few minutes she had attempted to get up and walk and fell. She had been trying to find her</p>			

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	<p>daughter. No injury resulted from the fall.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/10/16 at 9:21 a.m., indicated the root cause of the fall on 5/9/16 at 10:00 a.m., was she was looking for her daughter and stood up unassisted. She had called out for her daughter multiple times through out the day to all the people walking in the hallway. The IDT recommendation was the facility would do a urine dip to rule out a urinary tract infection.</p> <p>A "Consult Urine Dipstick Test Result" for Resident #A dated 5/10/16, indicated the test was negative.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 5/17/16 at 3:00 a.m., she was in her bedroom and tried to get up and go to the bathroom and fell on her bottom. No injury resulted from the fall.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 5/17/16 at 12:00 p.m., she was in the dining room and had attempted to maneuver around her own wheelchair while attempting to ambulate and fell over her wheelchair. No injury resulted from the fall.</p>			

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	<p>A "Progress Note" for Resident #A dated 5/17/16 at 5:43 p.m., indicated a new order was received for a self release alarming seat belt in place when she was seated in her wheelchair. She would be checked every hour and released every 2 hours.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/18/16 at 9:45 a.m., indicated the root cause of the fall on 5/17/16 at 3:00 a.m., and 5/17/16 at 12:00 p.m., was she didn't have any safety awareness and would not ask for assistance when transferring and ambulating. The IDT recommendation was she would have a self release alarming seat belt to alert staff of unassisted transfers. She was able to release the seat belt.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 5/24/16 at 3:30 a.m., she was in her bedroom and tried to get up and go to the bathroom unassisted and tripped over her oxygen cord and fell. She had hit her forehead, resulting in a cut to her forehead and a scrape to the top of her nose. Both alarms had been sounding at the same time. A nurse and a CNA had been in the residents room next door. The CNA went to Resident #A's room</p>			

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	<p>and was unable to stop Resident #A from falling and observed her hit her head on the floor. Resident #A was sent to a hospital for evaluation and treatment.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 5/25/16 at 9:57 a.m., indicated the root cause of the fall on 5/24/16 at 3:30 a.m., was she had been attempting to go to the restroom. The IDT recommendation was she was sent to the emergency room for evaluation, and the MD would be notified of her frequency in urine.</p> <p>A "Progress Note" for Resident #A dated 5/27/16 at 4:00 p.m., indicated a new order was received to discontinue her self release alarming seat belt and she would have a break away lap buddy while she was seated in her wheelchair. She would be checked every hour and released every 2 hours.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 6/1/16 at 3:15 a.m., she apparently turned off her seat alarm and no one had heard her get up in the east wing lobby. She had fell on her buttock and sustained a skin tear to the top of her right hand measuring 1.2 cm in length. Staff had tried to explain to Resident #A about</p>			

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	<p>asking for help to get up and she had said "what happens, happens." The area on top of her right hand had been cleansed and a dressing had been applied.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 6/1/16 at 12:03 p.m., indicated the root cause of the fall on 6/1/16 at 3:15 a.m., was she frequently became active around 3:00 a.m. and had no sense of safety awareness. She would attempt to walk without assistance. The IDT recommendation was staff would offer her to get ready for the day at 3:00 a.m., if she was awake, because she was frequently restless at that time.</p> <p>The facility had not initiated close supervision for Resident #A or placed her on a walking or toileting restorative program after she had suffered 11 falls since her re-admission to the facility on 4/7/16, from a hospital where she had a surgical hip repair. The facility initiated a restorative grooming, walking, and toileting program following an interview with the MDS Coordinator on 6/2/16 at 10:50 a.m.</p> <p>A "Nursing-Occurrence Initial Assessment" for Resident #A indicated on 6/6/16 at 12:30 a.m., a CNA heard Resident #A's alarm sounding and rushed</p>			

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	<p>into her bedroom. When the CNA had turned on Resident #A's light she had seen Resident #A fall over her oxygen tank hitting her head on her bedside table. When a nurse had entered Resident #A's bedroom she had observed Resident #A sitting on the floor beside her bedside table, attempting to get up. Resident #A had been able to move all extremities and had no complaint of pain or no sign of injury. Neurological checks were initiated and were within normal limits. Resident #A had become frustrated with staff and stated "just get me up I've got to go pee." Resident #A had been assisted to the bathroom and back to bed.</p> <p>A "Post Occurrence IDT & Fall Risk Assessment" for Resident #A dated 6/7/16 at 7:40 a.m., indicated the root cause of the fall on 6/6/16 at 12:30 a.m., was she had needed to go to the bathroom and had not asked for assistance. The IDT recommendation was she got up in the middle of the night to go to the bathroom. She had been offered to go to the bathroom at 3:30 a.m., nightly. She had continued to be checked every 2 hours. The facility would increase staff during the night hours to provide 1:1, to supervise her more closely.</p> <p>On 5/31/16 at 12:26 p.m., Resident #A was observed seated upright in her</p>			

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	<p>wheelchair in the dining room with a break away alarming lap buddy connected to the arms of her wheelchair. She had a dark scab on her forehead, and purplish discoloration around her left eye and forehead. Her lap buddy was removed by staff and she was positioned up close to the dining table. The lap buddy alarmed when it was removed from her wheelchair.</p> <p>On 6/2/16 at 10:45 a.m., LPN #4 indicated Resident #A was no longer in therapy. She was occasionally incontinent. She was not on a toileting program.</p> <p>An interview with the MDS Coordinator on 6/2/16 at 10:50 a.m., indicated he had spoke with a therapy staff approximately 2 weeks prior and discussed what residents may benefit from a restorative program. He indicated Resident #A was not on any restorative programs but he planned to put her on a restorative toileting, walking, and grooming program.</p> <p>On 6/2/16 at 12:30 p.m., Resident #A was observed seated upright in her wheelchair in the dining room at a dining table with a pad alarm on her wheelchair seat and a break away alarming lab buddy connected to the arms of her wheelchair.</p>			

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	<p>She had a skin tear on the top of her right hand covered with a clear film dressing. She continued to have a dark scab on her forehead and purplish discoloration around her left eye and forehead. She has a scratch across the bridge of her nose.</p> <p>An interview with Resident #A's daughter on 6/2/16 at 2:32 p.m., indicated her mother had fell and blackened her eye last week and had to have stitches in her head. The facility had informed her that her mother had tripped over her oxygen tubing and fell. She indicated the facility had called her once or twice a week and informed her that her mother had fell. She indicated her mother had fallen in the facility in February 2016 and had broken her hip.</p> <p>On 6/3/16 at 12:14 p.m., Resident #A stood up independently from a dining chair in the dining room and began to ambulate. The Assistant Director of Nursing (ADON) joined Resident #A and assisted her to ambulate outside the facility's front doors with the use of a gait belt. Once outside, Resident #A sat down on a bench.</p> <p>On 6/6/16 at 9:42 a.m., Resident #A was observed seated in a soft recliner in the TV room across from the nurses station. She asked "do you know where the</p>			

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	<p>restroom is?" RN #2 and RN #3 assisted Resident #A to the bathroom with the use of a gait belt. Resident #A ambulated to the bathroom adjoined to her bedroom and lowered her slacks and brief as she sat down on the toilet. Resident #A urinated in the toilet and cleaned herself with toilet paper before getting up. Resident #A had been pleasantly confused and had not recognized her own bedroom when she had exited the bathroom, and stated "I have a bedspread just like that." When Resident #A was finished in the bathroom she ambulated through her bedroom and back to the TV room assisted by RN #2 and RN #3 with the use of a gait belt and sat back down in the soft recliner.</p> <p>On 6/6/16 at 10:09 a.m., Resident #A was observed ambulating outside the facility's front doors with assistance from the ADON and LPN #5 and use of a gait belt. Once outside, Resident #A sat down on a bench.</p> <p>On 6/6/16 at 10:47 a.m., Resident #A was observed still seated outside on a bench with peers and staff. She was seated upright and had her legs crossed.</p> <p>An interview with Physical Therapist Assistant #1 on 6/6/16 at 10:56 a.m., indicated Resident #A had been</p>			

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	<p>discharged from all therapies and staff should be asking her to walk daily. She indicated she felt Resident #A was a candidate for a walking restorative program. She was not sure if it was a program that could be followed through by Resident #A on a daily basis. When Resident #A was in therapy there were days she wouldn't walk because she didn't feel like it and then other days she would. Therapy staff tried to catch Resident #A when she was getting up on her own and trying to walk. The MDS Coordinator and herself had discussed a walking program to meals for Resident #A and they had just decided staff would ask Resident #A to walk and give her the option. They had never set up a walking restorative program.</p> <p>An interview with the Director of Nursing (DON) on 6/6/16 at 12:41 p.m., indicated Resident #A's 30 minute checks had been discontinued when she received an order for a self releasing belt. Resident #A currently used a break away lap buddy and staff checked her every hour and released the lap buddy every 2 hours. Resident #A was actually checked more often because she was busy and tried to get up. The staff were seeing a trend in Resident #A falling at night. When staff were doing bed checks at night it took 2 staff so there was not</p>			

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	<p>much supervision at night. She indicated the facility was adding a staff member so staff could monitor Resident #A while the other 2 staff did bed checks. Resident #A seemed to get up around 3:00 a.m., so she was having staff offer to toilet her and get her up if she wanted. Resident #A had fell in her room that morning at 12:30 a.m. The staff were doing neurological checks because they had not seen her fall. Resident #A had said she was going to the bathroom. Resident #A typically told staff when she needed to go to the restroom. Resident #A was on a toileting program for every 2 to 3 hours through the night, upon rising, before and after meals, and at bedtime. The facility had done a post void residual for Resident #A times 3 to see if she had urinary retention, but were not seeing a problem. The facility had also done a urine dip that was negative. Resident #A was most often continent of her bowel and bladder and it seemed like that was what Resident #A was always trying to do when she got up and that was why she was on a toileting restorative program. She had spoke with the MDS Coordinator and he informed her he was developing Resident #A a walking and grooming restorative program. She was unsure why Resident #A wasn't on any restorative programs prior.</p>			

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	<p>On 6/7/16 at 11:25 a.m., Resident #A was observed seated upright in her wheelchair in the TV room across from the nurses station. She had a break away alarming lap buddy attached to the arms of her wheelchair. She continued to have a dark scabbed area on her forehead, faded purplish discoloration around her left eye and forehead, and a skin tear on top of her right had covered with a clear dressing. She pulled on her lab buddy and it hadn't broke away or alarmed.</p> <p>On 6/7/16 at 11:38 a.m., Activity Staff #1 checked Resident #A's lap buddy and the alarm sounded. She propelled Resident #A to the dining room in her wheelchair.</p> <p>The "Restorative Nursing Program Procedures" provided by the Administrator on 6/8/16 at 11:00 a.m., indicated the following: "A. Purpose: 1. To provide services which promote the highest level of functioning in activities of daily living. 2. Restorative nursing services include: a. Passive and active range of motion exercises. b. Assistance and instruction in activities in daily living. c. Maintenance programs after formal therapy programs. d. Use of self help devices. e. Ambulation programs for gait training and transfers. f. Bowel and bladder training and/or incontinence management...."</p>			

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F 0329 SS=D Bldg. 00	<p>This federal tag relates to Complaint IN00200001.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) 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.</p> <p>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.</p> <p>Based on observation, record review, and interview the facility failed to ensure that</p>	F 0329	It is the policy of Miller's Merry Manor, Rushville that each resident's drug regimen is free from unnecessary drugs. An	06/30/2016

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	<p>there was adequate supporting documentation of behaviors for the continued use of an antipsychotic medication related to unnecessary medications for 1 of 5 residents reviewed for unnecessary drug use (Resident #44).</p> <p>Findings include:</p> <p>Review of Resident #44's record on 6/6/16 at 9:30 a.m., indicated diagnoses included but, were not limited to hypertension, agitation, dementia with behavioral disturbance and edema.</p> <p>Review of recapitulation orders dated 4/3/16 indicated Seroquel 100 mg bid (two times a day) diagnosis: dementia with behavioral disturbances, started 3/31/16</p> <p>A record review on 6/6/16 at 9:50 a.m., of "Facility Behavior/Psychotropic Med Quarterly Review Assessment dated 4/7/16, indicated...</p> <p>B. 1. Is the resident followed by Psychiatrist, or mental health services? No, family requests that resid. is not seen by psychiatrist.</p> <p>2. Has the resident had a physical or mental decline this quarter which would warrant reduction or discontinuation of psychoactive medication? No...</p>		<p>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.</p> <p>Resident #44 Medication regimen has been reviewed by physician. This resident no longer resides at the facility. All residents receiving anti-psychotic medications have the potential to be affected. Review of all anti-psychotic medications will be completed to ensure proper diagnosis in place for use. Staff re-educated on need for proper diagnosis for anti-psychotic medications. To ensure this does not reoccur the DON/Designee will complete the QA Audit Tool titled "Psychopharmacological Medication Review" (Attachment G) daily for thirty days, then weekly for four weeks, and then monthly thereafter. Any concerns to be addressed immediately and logged on the QA Problem Summary Log (Attachment B). Summary log will be reviewed/ revised and followed in the monthly facility Quality Assurance meeting.</p>				

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	<p>C. 1. Medication, dosage, and original start date. List any changes to this medication, dosage reductions/increases, include dates and dosages. Seroquel 100 mg New admission as of 3/31/16.</p> <p>2. Diagnosis for use of this medication. Dementia with behavioral disturbances...</p> <p>5. Behavior currently being monitored (current tracker): must track symptoms of what med is being given for (diagnosis). Specific target behaviors that present a danger to self or others. Hitting, kicking, and pinching staff during care.</p> <p>6. Review frequency and evaluation of 3 months worth of behavior documented on the Behavior Tracker. Note shifts, setting and effectiveness of interventions. Resident is a new admission. Staff reports that this has occurred a few times..."</p> <p>Behavior tracking form dated April 2016, indicated "Intervention/Task: Document physical behavior: #1: Hitting, kicking and pinching staff during care. #2: introduce yourself at each approach with a smile and friendly manner. #3: slow down and explain the task prior to starting. #4: leave in a safe manner and reproach later. First behavior documented was for April 12 on evening shift- one time only, in a quiet room...,April 13 on night shift-</p>			

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	<p>several times, personal care, continuous. April 14 on night shift- one time only, personal care..., April 15 on night shift-several times, personal care..., April 19 evening shift- continuous, quiet room..., April 20 evening shift- one time only, quiet room..., April 23 on night shift- one time only, personal care...April 26 on evening shift- continuous, quiet room..., April 27 night shift- several times, personal care..."</p> <p>Behavior tracking form dated May 2016, indicated "May 1 on evening and night shifts- continuous, quiet room..., May 7 on evening shift- several times, personal care..., May 1 on Night shift- one time only, personal care..., May 8 day shift-one time only, personal care..., May 12 on night shift- several times, personal care..., May 17 on evening shift-continuous, quiet room..."</p> <p>Behavior tracking form dated June 2016, indicated No behaviors occurred from June 1 through June 6.</p> <p>A progress note dated 4/8/16 at 10:34 p.m., "Received new order from Physician #1, Seroquel 100 mg tab TID for agitation. Faxed pharmacy, on MAR (medication administration record), daughter and son aware."</p>			

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	<p>A progress note dated 4/28/16 at 1:26 p.m., "New order received from Physician #1 as follows: Seroquel clarification - use for dementia with behavioral disturbances."</p> <p>A physician's order dated 4/8/16, indicated "Seroquel 100 mg PO (by mouth) tid (three times a day) for agitation."</p> <p>Physician's order dated 4/28/16, indicated "Seroquel clarification - for dementia with behavioral disturbance."</p> <p>On 5/31/16 at 1:53 p.m., an observation of Resident #44 indicated she was seated in a wheelchair with head in hands and elbows on soft padded lap buddy in TV room with peers. She has her eyes closed and is difficult to prompt awake, opens eyes and then closes them again.</p> <p>An MDS Admission Assessment dated 4/7/16, indicates "should Brief Interview for Mental Status be Conducted? No, Resident is rarely/never understood. Assessment for Mental Status- short term and long term memory: memory problem. Cognition- severely impaired she never or rarely made decisions".</p> <p>An interview on 6/6/16 at 1:55 p.m., with the Social Services Director indicated</p>			

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	<p>Resident #44's Physician increased her Seroquel on 4/8/16, there was no communication from the Physician or family as to why the medication was increased.</p> <p>On 6/7/16 at 10:40 a.m., an interview with RN #1 indicated she was not sure why Resident #44's Seroquel was increased on 4/8/16, she believed Resident's daughter asked Physician for it to be increased but was not sure why, as Resident has not had an increase in behaviors, no communication from Physician or daughter.</p> <p>An interview on 6/7/16 at 2:40 p.m., with Physician #1 indicated Resident has been hitting staff, and staff calls him frequently with Resident's behaviors during care. Increased Seroquel on 4/8/16, someone called me and reported that Resident #44 was having increased agitation, "I assumed it was facility staff but I don't know who it was."</p> <p>An interview on 6/7/16 at 3:20 p.m., with Social Services Director indicated "no one from the facility called the Physician about Resident #44 having increased agitation. I checked the progress notes and it would have been documented there but it was not."</p>			

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	<p>On 6/7/16 at 3:45 p.m., an interview with Pharmacy Consultant #1 indicated "the Physician has not responded to any of my recommendations for gradual dose reductions."</p> <p>A care plan for antipsychotic medication dated 4/1/16 with revision on 6/6/16 indicated "Focus- Behavior: Resident displays inappropriate physical behavioral issues as exhibited hitting, kicking, pinching staff during care. Family has refused psych services to evaluate and treat Resident... Goal- Resident will have no adverse side effects from medication through next review. Date initiated: 4/7/16... Interventions/Tasks- Black box warning for antipsychotic has been reviewed, administer psych medication as ordered, monitor medication side effects at least daily on psychotropic administration record, notify Physician as needed, monitor quarterly for medication gradual dose reduction through Pharmacy Consultant. Family is educated and consulting about a reduction of psychiatric medication each quarter, provide education and support to family as needed, Social Services to visit as needed, Psych Services to follow Resident as needed, document physical behavior #1: Hitting, kicking and pinching staff during care. #2: introduce</p>			

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	<p>yourself at each approach with a smile and friendly manner.</p> <p>#3: slow down and explain the task prior to starting. #4: leave in a safe manner and reproach later. Focus- Behavior: Resident displays mood issues as exhibited by: wringing hands, excessive worrying. Date initiated 6/3/16. Goal- Resident will have no adverse side effects from medication through next review. Resident will accept gentle reminders without incidents. Will display no episodes of crying, tearfulness or anxiety. Interventions/Tasks- Black box warning for antipsychotic has been reviewed, administer psych medication as ordered, monitor medication side effects at least daily on psychotropic administration record, notify Physician as needed, monitor quarterly for medication gradual dose reduction through Pharmacy Consultant and Psych Services, listen to concerns and follow-up on these promptly as needed, provide support and encouragement as needed, Social Services to visit as needed, provide education and support to family as needed, Psych Services to follow Resident as needed."</p> <p>Review of a document titled Psychotropic Drug Use Policy provided by the Director of Nursing on 6/7/16 at 10:10 a.m., indicated... "Procedure: 1.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2016
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NAME OF PROVIDER OR SUPPLIER MILLERS MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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(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
R 0000 Bldg. 00	<p>The facility will assure that medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication for use at the time the order for psychotropic medication is obtained/received..."</p> <p>3.1-48(a)(1) 3.1-48(a)(4) 3.1-48(a)(6)</p>	R 0000		
	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 18</p> <p>Sample: 7</p> <p>Millers Merry Manor was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>			