

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155571	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 11563 W 300 S DUNKIRK, IN 47336
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: August 19, 20, 21, 22 and 23, 2013</p> <p>Facility number: 000519 Provider number: 155571 AIM number: 100287230</p> <p>Survey team: Toni Maley, BSW- TC Linn Mackey, RN Karen K Koeberlein, RN Angela Selleck, RN</p> <p>Census bed type: SNF/NF: 32 SNF: 5 Total: 37</p> <p>Census payor type: Medicare: 4 Medicaid: 28 Other: 5 Total: 37</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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, interview and record review, the facility failed to ensure a resident who received both anti-hypertensive and psychoactive medications was monitored for lethargy and fatigue for 1 of 5 Residents who met the criteria for unnecessary medications (Resident #28).</p> <p>Findings include:</p> <p>Resident #28 was sleeping in her</p>	F000329	Plan of Correction for Dunkirk Annual 2013 F329: It is the policy of Miller's Merry Manor Dunkirk that each resident's drug regimen will be free from unnecessary drugs. Proper monitoring is to be done to ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff; each resident	09/20/2013			

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	<p>wheelchair during the following observations:</p> <p>8/20/13, 9:08 a.m. 8/20/13, 10:30 a.m. 8/20/13, 11:00 a.m. 8/21/13, 9:30 a.m. 8/21/13, 1:30 p.m. 8/22/13, 8:45 a.m. 8/22/13, 9:25 a.m. 8/22/13, 10:22 a.m.</p> <p>8/22/13, 11:15 a.m. while seated in her wheelchair at the dining room table awaiting lunch. Her head was down and her eyes were closed. She sat in this manner until 11:47 a.m. when a staff member woke her and placed her meal in front of her. She then put her head down and kept her eyes closed until 11:52 a.m., when a staff member again woke her and encouraged her to eat. Resident #28 took a few bites and appeared to be asleep with a fork in her hand, head bobbing, eyes closed. At 11:55 a.m. a staff member attempted to waken her again. She took a few bites and fell back asleep. At 12:03 p.m. a staff member woke Resident #28 and conversed with her for a few moments. Resident #28 then awoke and ate her lunch in a very slow manner.</p>		<p>receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed conditions; clinically significant adverse consequences are minimized; and the potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Resident #28 has remained unchanged. Clinical monitoring for adverse effects to current medications continues and is addressed on the HCP. An additional 2 week observation has been on going by staff to document any changes in normal function or routine. Recent medications reductions were completed on 8-22-13 per the attending physician. Psychoactive medications are reviewed routinely per the facility policy and as needed (see Attachment A). Resident has had no additional changes in cardiac medications. Physician is scheduled to review all medications again during visit 9-5-13. Resident does have tendency to sleep/nap often when she is up in her w/c. Staff offer to lie down or assist to recliner for rest periods and resident chooses to be in her w/c. Does attend scheduled activities. Care plan has been revised to reflect usual activity. Resident vital signs are stable and WNL. All residents have the potential to be affected</p>		

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	<p>8/22/13, 12:45 p.m. and 8/22/13, 2:38 p.m.</p> <p>Resident #28's record was reviewed on 8/21/13 at 3:00 p.m.</p> <p>Resident #28's current diagnoses included, but were not limited to, hypertension, depression and dementia with behavioral disturbances.</p> <p>Resident #28 had current physician's orders which included, but were not limited to, the following medications:</p> <p>a.) 6/1/13, Seroquel 25 mg, two times daily for dementia with behaviors. This medication was decreased 8/22/13 as part of a routine gradual dose reduction.</p> <p>b.) 3/5/12, Zoloft 100 mg, one daily for depression. This medication was decreased 8/22/13 as part of a routine gradual dose reduction.</p> <p>c.) 2/10/10, Lisinopril 100 mg, one daily for hypertension</p> <p>d.) 12/29/11, Furosemide 200 mg, one daily for hypertension</p> <p>e.) 4/30/08, Amlodipine 10 mg, one daily for hypertension</p> <p>f.) 4/30/08, Metoprolol 25 mg, one tablet two times daily for hypertension</p> <p>Resident #28 had a current, 6/7/13, care plan problem regarding</p>		<p>by this deficient practice. Resident medications are reviewed to ensure proper indication for useage and proper monitoring for adverse effects are in place. Medications are reviewed monthly and as needed by the facility (Attachment B). No other resident's have been identified with issues at this time. On-going monitoring will continue. Facility did one on one education with nursing staff 8- 22 -13 and reviewed monitoring and documentation for adverse drug effects (Attachment C). Another all staff inservice is scheduled for 9-20-13 to again review medication monitoring for adverse reactions. Will continue on-going facility review for medications. Any concerns/issues will be addressed with attending physician. Nursing staff administering medication will document any change in resident condition relating to possible adverse drug reactions in the EMR (electronic medical record) and notify the physician for further orders. QA tool Behavior and Antipsychotic Medication Review (Attachment D)will be completed by the DON/Designee quarterly on all residents receiving these classifications of medications. This audit will be ongoing. QA Tool Sedative/Hypnotic Drug Review (Attachment E) will be completed by the DON/Designee quarterly on all residents receiving this type of medication</p>		

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	<p>dementia with behavioral disturbances. An approach to this problem was to document possible side effects daily on the psychotropic medication record.</p> <p>Resident #28 had a current, 2/16/12, care plan problem regarding chronic cardiovascular disease, congestive heart failure and hypertension. An approach to this problem was to monitor for possible signs of decreased cardiac output such as fatigue, pallor and shortness of breath.</p> <p>Resident #28 had a current, 2/16/12, care plan problem regarding depression. An approach to this problem was to monitor medication side effects at least daily on the psychotropic medication record.</p> <p>Review of Resident #28's resident progress notes for June, July and August 2013 lacked any documented concerns with lethargy or fatigue. Review of Resident #28's psychotropic medication records for June, July and August 2013 showed no documentation of fatigue or lethargy.</p> <p>Resident #28 had a current, 7/21/13, quarterly Minimum Data Set</p>		<p>class. QA Tool Medication Review (Attachment F) will be completed on 10% of the resident population monthly. This tool will be utilized for all other drug classifications. This audit will be ongoing. Any issues identified on the QA audit tools will be addressed immediately. Issues will be logged on the monthly QA Summary Problem Log (Attachment G). The QA summary log will be reviewed in the monthly facility QA meeting. Date of completion is 9-20-13.</p>		

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	<p>assessment which indicated she was severely cognitively impaired, rarely or never made choices, understood others and was understood by others.</p> <p>During an 8/22/13, 9:26 a.m. interview, CNA #1 indicated Resident #28 usually slept in her wheelchair most of first shift.</p> <p>During an 8/22/13, 9:30 a.m., interview, LPN #2 indicated Resident #28 spent most of first shift asleep in her wheelchair. "She just falls asleep. It's not that she chooses to nap."</p> <p>During a 8/22/13, 3:00 p.m., interview, CNA #3 indicated it was common for Resident #28 to sleep in her wheelchair most of the day. "Recently we have had to wake her and tell her her meal has arrived."</p> <p>During a 8/22/13, 3:05 p.m., interview, CNA #4 indicated Resident #28 "sleeps a lot here lately."</p> <p>During a 8/22/13, 3:29 p.m., interview the RN Consultant indicated side effect monitoring should be documented on the psychotropic medication form and/or progress notes.</p> <p>During an 8/22/13, 9:33 a.m.,</p>						

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	<p>interview, The Director of Nursing indicated Resident #28 has a history of sleeping in her wheelchair. She indicated she was not aware Resident #28 had had an increase in sleeping or staff felt she was more lethargic or unable to stay awake. She indicated the facility had made medication adjustments but had not considered lethargy as a concern.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				