STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1900 N ALBER ST WABASH, IN 46992

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: November, 19, 20, 21, 22 and 25, 2013 Facility number: 000006 Provider number: 155006 AIM number: 100290220 Survey Team: Karen K Koeberlein, RN Shelley Reed, RN (11/19/13, 11/20/13, 11/21/13, 11/25/13) Toni Maley, BSW Jason Mench, RN Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 7 Medicaid: 49 Other: 9 Total: 65 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed by Debora	F000000		

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 determined that other safegaurds 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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	Barth, RN.			

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F000309 SS=D	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 interview and record review, the facility failed to identify effective and ineffective approaches to behavior management in order to modify and/or revise dementia behavior management plans for 3 of 5 residents reviewed for unnecessary medications. (Resident #18, #46 and #57) Findings include: 1. The clinical record for Resident #57 was reviewed on 11/20/13 at 2:23 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbances, acute renal failure, depressive disorder, diabetes mellitus and hypertension. The quarterly Minimum Data Set (MDS) assessment, dated 9/5/13, indicated Resident #57 was cognitively impaired. Resident #57 presented physical behaviors towards	F000309	F309 Provide Care/Services for highest Well Being: It is the policy of Miller's Merry Manor East 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. Residents #18, #46 and #57 had no adverse effects as a result of this deficient practice. All behavior care plans have been reviewed for these residents to ensure current interventions are appropriate. All residents have the potential to be affected by this deficient practice. No negative outcomes have been identified. The company has revised the policy and procedure for the behavior documentation. The new approved documentation will include what specific interventions the staff are utilizing (Attachments E1 and E2") for resident's behaviors. The SSD/Designee will be responsible for daily review of the behavior documentation. When interventions are noted to be ineffective three times within a	12/23/2013

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	others for 1 to 3 days of the assessment period. Resident #57 received the following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, ambulation-extensive assistance with two person assist, dressing-extensive assistance with one person assist and hygiene-extensive assistance with one person assist. The health care plan, dated 9/16/13, indicated Resident #57 displayed inappropriate physical behaviors exhibited by: anger at staff as evidenced by hitting and kicking staff during care. Interventions for the problem included, but were not limited to, "remaining calm and explain procedure, allow to sleep in, leave alone and approach a short time later and offer options regarding care." During review of the behavior tracking sheet, Resident #57 had behaviors on 11/1/13, 11/3/13, 11/11/13, 10/1/13, 10/2/13, 10/10/13, 10/12/13, 10/14/13, 10/17/13, 10/19/13, 10/20/13, 10/24/13 and 10/29/13. The tried interventions were successful on 14 occasions. On two occasions, the attempted interventions were unsuccessful.		five day period, the IDT will review the resident's behavior plan and make changes as needed to the plan of care. All staff will be educated (12/12/13) on the policy changes to the behavior monitoring. To ensure that ineffective interventions are reviewed and changes are made timely to the health care plan, the DON/Designee will complete the QA tool "Behavior and Antipsychotic Medications Review" (Attachment F) monthly on 1/3 of the residents with behavior tracking in place for the next three months. This tool will be completed quarterly thereafter. Any identified issues will be addressed immediately and logged on the QA Summary Log (Attachment C). This will be followed and reviewed in the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance.	

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	Resident #57 was being given Risperidone (a medication used for dementia with behavioral disturbances) 0.25 mg at night. 2. The clinical record for Resident #18 was reviewed on 11/21/13 at 8:38 a.m. Diagnoses for the resident included, but were not limited to, senile dementia, acute reaction to stress, depression, paralysis agitans, chronic airway obstruction, and vitamin D deficiency. The quarterly minimum data set (MDS) assessment, dated 11/12/13, indicated Resident #18 was cognitively impaired. The most current health care plan, dated 11/12/13, indicated Resident #18 displayed behaviors related to mood issues exhibited by: hearing and seeing things that were not there (animals, bugs on the wall, people talking about him). Approaches to the problem included, but were not limited to, "provide reality for the resident, encourage diversional activities, provide support and encouragement as needed, and administer psychiatric medication as ordered." Resident #18 also displayed signs			

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	and symptoms of depression related to loss of independence shown by tearfulness, worrying about children, and negative remarks. Approaches included, but were not limited to, "encourage resident to attend social activities, social services to visit as needed, notify physician as needed, and administer antidepressants as ordered." During review of the behavior tracking sheets for September 20, 2013 through November 22, 2013 , Resident #18 had behaviors on 9/20/13, 9/28/13, 10/14/13, 10/17/13, 10/23/13, and 11/8/13. The tried approaches were successful on 4 occasions, and unsuccessful on 2 occasions. Resident #18 had a current medication order for Seroquel 12.5 mg (anti psychotic) every 6 hours per day while awake, effexor 25mg (an anti-depressant) daily at 9:00 a. m., and aricept 10 mg (for dementia) at bedtime. 3. The clinical record for Resident #46 was reviewed on 11/20/13 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, dementia with delusional behaviors, peripheral vascular disease, diabetes and depression.			

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	The health care plan assessment dated 11/7/13, indicated Resident #46 displayed inappropriate physical behaviors exhibited by: throwing objects, yelling/screaming at staff and family. Interventions for the problem included, but were not limited to, "approach resident in a calm manner and explain task, ask resident if she would like to take a walk with you or if she needs help with something, if resident becomes upset, leave in a safe manner and approach later." During review of the behavior tracking sheet for September 20, 2013 to November 22, 2013, Resident #46 had behaviors on 10/9/13, 10/12/13 and 10/15/13. The tried interventions were successful on 5 of 5 occasions. The clinical record did not identify which interventions had been tried. Resident #46 was being given Risperidone (a medication used dementia with behavioral disturbances) 0.5 mg at night. 4. During an interview on 11/20/13 at 3:43 p.m., the SSD indicated the facility did not document the specific interventions that were attempted by the staff during behaviors. She indicated the computer program the facility used only allowed the staff			

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	to document if the attempted interventions had improved or were unchanged. When asked how the facility monitored and assessed which intervention was successful, she indicated if the tried interventions were unsuccessful; the staff attempted all the interventions listed on the care plan. She indicated she could not tell which intervention was actually attempted. During an interview on 11/21/13 at 9:30 a.m., the DoN indicated the facility did not document the specific intervention that had been attempted, only whether the intervention had been effective or not. During an interview on 11/21/13 at 12:00 p.m., the Corporate Nurse indicated the facility discussed the missing data recently in a QAA (Quality Assessment and Assurance) meeting. 5. Review of a current facility policy dated 4/3/13, titled "Behavior Assessment and Management", which was provided by the DoN on 11/25/13 at 9:20 a.m., indicated the following: "1. Purpose: To provide a systematic			

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	method for identification of specific behaviors that may impact the resident ' s quality of life or cause concern to the resident. Target behaviors are a concern ... 2. New Behavior Assessment Procedure: A. When a new or worsened behavior occurs ... I. Effectiveness of the interventions will be reviewed quarterly and PRN by the IDT. If no behaviors are noted for 90 days the behavior monitoring record and care plan may be discontinued if the resident is not receiving medication to manage the behavioral J. If ineffectiveness is noted the IDT team will be responsible to review and update the plan of care with new interventions." 3.1-37(a)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident 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 implement care plan approaches to prevent falls for 1 of 3 residents reviewed for accidents. (Resident #39) Findings include: The clinical record for Resident #39 was reviewed on 11/20/13 at 2:53 p.m. Resident #39's current diagnoses included, but were not limited to, dementia, muscle weakness, osteoporosis, depression, and anxiety. Resident #39 had a current physicians order for lorazepam 0.5 mg (an anti-depressant) once daily at bedtime, and celexa 20 mg (an anti-depressant) once daily at 9:00 a.m. The current health care plan, dated 6/21/13, indicated Resident #39 to be at risk for falls related to the use of antipsychotic medications and muscle	F000323	F-Tag 323 Free of Accident Hazards/Supervision/Devices: It is the policy of Miller's Merry Manor, Wabash East 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. Resident #39: Resident had no negative outcome as result of the deficient practice. Resident's fall prevention care plan has been reviewed and updated. Resident is very mobile in the facility with her walker. Transfers independently and also walks independently with assist of her walker. Has call light available for assistance. All resident are at risk to be affected by deficient practice. All resident's who are at risk for falls will have their care plans reviewed and updated as needed to ensure all interventions remain appropriate. To ensure this deficient practice does not reoccur The DON/Designee will be responsible to complete the QA tool titled "Fall Risk Management Review" (Attachment D) weekly x4 weeks, then monthly thereafter to ensure	12/23/2013

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	weakness. Approaches to the problem included, but were not limited to, "call light within reach at all times, frequently used items within reach at all times, and assistance with ADL'S (activities of daily living)." During an observation on 11/21/13 at 10:05 a.m., Resident #39 was found to be awake and alert, lying on her bed watching television. The call light was not in reach. Additional observations were made of Resident #39 in her room on 11/21/13 at 10:40 a.m., and 11:50 a.m. The call light was not in the resident's reach any or the observed times. On 11/22/13 at 9:55 a.m., and 11:00 a.m., observations were made of Resident #39 in her room lying on her bed watching television with the call light out of reach, under the bedspread at the end of the bed. During an interview on 11/21/13 at 10:30 a.m., LPN #3 indicated knowledge of Resident #39's careplan approach of having the call light within reach at all times. An observation made on this same date at 10:40 a.m., after LPN #3 had provided medication to Resident #39 and had left the room, found Resident #39 in her room, lying on the bed, with the		ongoing compliance. Any identified issues will be immediately corrected and documented on facility QA Summary Log (Attachment C).. Logs are reviewed during the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance. .	

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	call light out of reach. A policy obtained from the DON on 11/25/13 at 9:00 a.m., entitled "Fall Management Procedure Purpose stated, 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 possible." 3.1-45(a)(1)			

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to post complete nurse staffing for 3 of 3 days observed (11/19/13, 11/20/13 and 11/25/13). This deficient practice had the potential to impact 65 of 65	F000356	F356 Nurse Staffing Information: It is the policy of Miller's Merry Manor, Wabash East to post licensed and unlicensed staffing on a daily basis for those individuals directly responsible for resident care according to state	12/23/2013

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	residents. Findings include: During an 11/19/13, 10:30 a.m., observation, the posted facility "Daily Nursing Staffing Form" lacked documented actual hours worked and total hours worked. The form did contain an area for said information. These areas were blank. During an 11/20/13, 9:30 a.m., observation, the posted facility "Daily Nursing Staffing Form" lacked documented actual hours worked and total hours worked. The form did contain an area for said information. These areas were blank. During an 11/25/13, 1:10 p.m., observation, the posted facility "Daily Nursing Staffing Form" lacked documented actual hours worked and total hours worked. The form did contain an area for said information. These areas were blank. During an 11/25/13, 1:15 p.m., interview the Director of Nursing indicated she was unaware the posted staffing had not reflected actual hours worked or total hours worked. She indicated the form should be completed prior to posting.		and federal guidelines. The "Daily Nurse Staffing Form" is completed on a daily basis by the third shift charge nurse and is located in area that is readily accessible to all visitors and residents, including those in wheelchairs. The form has been revised and will include the following information: Facility location, Current date, resident census, the total hours scheduled for registered nurses, licensed nurses and certified nursing assistants scheduled to work on each shift (Attachment A). Any staffing changes made for the day after the form is posted will be reflected on the form itself. Actual hours worked will be completed the following day from the payroll records and totals at the bottom the form completed. The completed form will then remain posted until the following day. At any one time, there shall be two forms posted. This will include the current form for the day and the form for the day prior that is completed entirely. The QA tool "Nursing Services Review"(Attachment B) will be utilized to ensure that the Daily Staffing Nursing Form is posted daily with the accurate information to meet required guidelines. This form will be completed 2x weekly for 2 weeks then weekly x 2 weeks and then quarterly thereafter. Any concerns issues will be addressed and logged on the Monthly QA	

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			Summary Log (Attachment C). This will be reviewed and discussed in the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance.	