STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 6, 7, 8, 9, 10 and 14, 2014. Facility number: 000041 Provider number: 155102 AIM number: 100275400 Survey Team: Lora Swanson, RN-TC Sharon Ewing, RN Deb Kammeyer, RN (10/6,10/7, 10/8, 10/9, 10/10, 2014) Julie Wagoner, RN Census bed type: SNF: 8 SNF/NF: 76 Residential: 1 Total: 85 Census payor type: Medicare: 9 Medicaid: 68 Other: 7 Total: 84 Residential Sample: 1	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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on October 20, 2014, by Brenda Meredith, R.N.			
F000329 SS=D	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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and	F000329	**We are requesting paper compliance for this deficiency.**	11/13/2014

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	interview, the facility failed to ensure a vitamin supplement was monitored effectively and the use of a routine anti-anxiety medication was indicated for 1 of 5 residents reviewed for unnecessary medications. (Resident #91) Findings include: The clinical record for Resident #91 was reviewed on 10/08/14 at 2:00 P.M. Resident #91 was admitted to the facility on 04/02/14 with diagnoses, including but not limited to, senile dementia, malaise and fatigue, atrial fibrillation, hypothyroidism, hypertension, urine retention, congestive heart failure, diabetes, hyperlipidemia, osteoarthrosis, esophageal reflux, chronic airway obstruction, dysphasia, psychosis, and diabetes with neurological manifestations. Resident #91 was observed, on 10/08/2014 at 2:49 P.M., in her low bed asleep. There was no alarm noted to be plugged into the bed but the mattress was not visible clearly due to the resident's blankets and positioning. The call light was not in reach as it was draped over a recliner about 5 feet from the resident's bed. Resident #91 was observed, on		We are also requesting paper IDR review. **F-Tag 329**: **Unnecessary Medications:** It is the policy of Miller's Merry Manor, Plymouth that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, without adequate indication for use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons. **Resident #91**: Regarding the medication, Vitamin D, the physician was updated and order for the Vit D level was obtained. The lab results (Attachment A) clearly show that the resident's Vit D Level still shows inadequate levels. The physician was updated with results and resident continues on the same dose of the medication. Regarding the medication, klonopin, the Psych Nurse Practitioner was consulted and did review the resident's medication regimen on 10-16-14 (Attachment B). No changes were recommended in resident's psychoactive medication regimen. All residents could be affected by this deficient practice. The facility will review all medication regimens for residents to ensure proper reason for use is in place and also that supportive documentation is in place in the clinical record. The pharmacy consultant will continue to make	

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	10/09/2014 at 9:25 A.M., in the therapy room seated in her wheelchair. Her head was down and she appeared to be sleeping. Interview with the Physical Therapist indicated he had ambulated the resident with a gait belt, limited assistance, and a wheelchair behind her. He indicated the resident sometimes could follow instructions, seemed "scared" to stand, and had instability of her knees. He indicated she was also not very cooperative in the therapy room because she kept falling asleep and told him she was too tired. Resident #91 was observed, on 10/09/2014 at 11:11 A.M., in bed asleep. The resident's body pillow was on the outside edge of her low bed, the other side of the low bed was against the wall. The call light was within reach and the resident's wheelchair was about a foot from her bed. The wheelchair was noted to have an alarmed seat belt and a dycem (a non-slip device). Resident #91 was observed, on 10/09/2014 at 2:44 P.M., lying in her bed. There was a body pillow on the outside edge of her bed. Her bed was elevated and the head of the bed was flat. The licensed nurse was observed attempting to feed the resident a pudding thick food item.		monthly visits to complete onsite drug regimen reviews and will submit recommendations to the DON. The DON or other designee will be responsible to communicate pharmacy recommendations to the physician and ensure timely physician response/follow up. The facility will continue monthly behavior meetings to review residents who are prescribed psychoactive and psychopharmacological medications, behavior patterns/target behaviors, and will ensure proper clinical documentation is present for indications for use. Nurses will be re-educated regarding requirements for medication use and supportive documentation guidelines by 11/13/14. To ensure this deficient practice does not reoccur,, the DON/Designee will complete the QA Audit tool “New Medication Review” (Attachment C). This tool will be completed daily x 30 day, then weekly for four weeks, then monthly thereafter for 4 months. Any issues noted will be immediately addressed and logged on the “QA Problem Summary Log” (Attachment D). The summary log will be reviewed in the facility’s monthly QA meeting. Date of Completion: November 13, 2014 IDR for F329 To whom it may concern,	

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	Resident #91 was observed, on 10/10/2014 at 10:55 A.M., in the hallway being ambulated by two staff members. The resident was very drowsy and it took several cues and two attempts to get her to follow through with the request to ambulate. The resident kept repeating "help me." A dycem and an alarming seatbelt were noted on the resident's wheelchair which was pushed behind her. After she ambulated, she was given her baby doll to hold and she was seated in her wheelchair with the seat belt attached. She then was noted to propel her wheelchair from the hallway back into her room with her feet. The physician's orders for Resident #91, current on the August 2014 rewrites, included the antianxiety medication, Lorazepam 0.5 mg (milligrams) one tablet twice a day as needed (PRN) for anxiety. On 08/20/14, a physician order, was received to increase the Lorazepam 0.5 mg from twice a day as needed to three times a day as needed. Nursing notes, from 08/14/14 - 08/20/14, indicated the resident was having issues with urinary retention. Nursing notes and the PRN medication sheet, from 08/12/14		Miller's Merry Manor Plymouth respectfully requests paper review for the citation of F329. The facility does feel that resident #91 did have the proper indications for use in place for the medications Vitamin D and Klonopin. Resident was admitted to the facility on 4-2-14 with multiple medical diagnoses including A-Fib, CHF, DM Type II, Chronic UTI's, Hyperlipidemia, Osteoarthritis, GERD, CAD, COPD, Weakness and Dementia. Regarding the use of the Vitamin D: The physician had seen the resident in the facility 4-28-14. All medications and previous labs were reviewed. On 4-29-14 the order was received for Vitamin D 50,000 units monthly. Per standards of practice, the use of Vitamin D is indicated for Vitamin D deficiency. The physician did not feel the need to draw an unnecessary lab to prove his suspicion of Vitamin D deficiency due to resident #91's risk factors. Resident #91's risk factors for Vitamin D deficiency are age, lack of sun exposure, and poor intestinal absorption. According to Dr. Alfred Denio, in the peer reviewed article Vitamin D Deficiency: the silent Epidemic of the Elderly, he stated that anyone over the age of 70 produces less than 30 percent of the Vitamin D that a younger person	

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	- 08/20/14, indicated the resident was having anxiety related to her urinary issues. The PRN medication sheet indicated the resident was given the anxiety medication 7 times during the 8 days and the medication was effective 5 of 7 times. Nursing notes, dated 08/20/14 at 2:30 P.M., indicated the resident was hallucinating and conversing with people that were not present. The non-pharmalogical interventions were not successful. On 08/21/14, the resident was evaluated by the psychiatrist and the antipsychotic medication, Seroquel was ordered. A urinalysis test was also ordered on 08/21/14. On 08/24/14, an antibiotic was ordered to treat a urinary tract infection. Nursing notes, from 08/22/14 - 09/03/14, indicated there were no notes regarding resident behavior issues. A new behavior note assessment, dated 08/25/14, indicated the resident was pacing up and down the hallway, yelling "help me." The resident could not verbalize her needs. The resident was placed in a recliner, toileted, repositioned in her wheelchair, offered food and drink, assessed for pain with no relief in her		does with the same exposure (Attachment A). He also stated that there is a decrease in Vitamin D absorption in the intestines above the age of 70(Attachment A). Combine that with the fact that resident #91 resides in a long-term care facility in northern Indiana causing decreased sun exposure this puts resident # 91 at high risk for Vitamin D deficiency. Dr. James Judge of the American Geriatrics Society stated, to achieve optimum vitamin D levels 4000 IU of Vitamin D were needed from all sources (Attachment B). He stated that in older adults' sun exposure and diet could not reach these levels and supplementation was needed (Attachment B). Dr. Judge also stated, clinicians generally do not need to measure Vitamin D levels in patients receiving adequate supplementation (Attachment B). He then went on to state that the normal supplementation is 1600 to 2000IU daily and could be dosed daily, weekly, biweekly, monthly and even up to every three months(Attachment B). The facility did contact the physician and a Vit D level was ordered. The results of the lab indicate the resident's level of Vitamin D remains inadequate (Attachment C). Because of the above information, The facility believes the Vitamin D 50,000 IU was a needed med and a lab was not needed to prove this need given resident #91's risk factors and	

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	agitation. She was not offered any antianxiety medication. A new behavior note assessment, dated 08/26/14, during the night shift indicated the resident was yelling for help while in her bed. After nonpharmalogical interventions were attempted and were only briefly successful, she was given antianxiety medication and it was successful in controlling her anxiety. A follow up of the new behavior note, completed on the day shift for 08/26/14, indicated the resident was yelling for help and non-pharmalogical interventions were not successful in redirecting her behavior. A medication administration record entry, dated 08/26/14 at 2:30 P.M., indicated the resident was given antianxiety medication and it was effective. A follow up of the new behavior note, completed on the night shift for 08/28/14, indicated the resident was anxious regarding her need to void. The note indicated she was given pain medication and antianxiety medication and with 1:1 interventions and giving her a baby doll, the interventions were effective. The note also indicated the resident was currently being treated for a urinary tract infection.		Vitamin D dose. Regarding the use of the routine klonopin ordered 9-4-14: Resident was noted with increased anxiety and behaviors including visual hallucinations and delusions. The primary care physician was consulted on 8-20-14 and increased PRN Ativan order to TID as needed. An order was received on 8-21-14 for the resident to be evaluated by the Rounding Provider Psych Nurse. As evidenced by the PRN Log for the month of August, the resident had the PRN Ativan administered on multiple occasions. The result of the medication was at times effective in slight reduction of her anxiety, however was not fully effective (Attachment D). Psych nurse did see the resident on 8-21-14 and new order was received for Seroquel (Attachment E). As noted per the PRN Log for the months of August and September, following the addition of the Seroquel, the resident continued to require administration of the PRN Ativan on several occasions Attachment D & G). The resident was re-evaluated by the psych nurse again on 9-4-14. At that time medication changes were made and Ativan was discontinued and Lexapro and klonopin were ordered to stabilize the resident's anxiety and agitation (Attachment F). Clinical studies have shown that a standing dose of medication, such as clonazepam, is sometimes the best	

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	The PRN medication administration record, from 08/22/04 - 08/31/14, indicated the resident was administered antianxiety medication 6 times and the intervention was successful 4 of the 6 times and slightly successful on the other two occasions. The PRN record, from 09/01/14 - 09/03/14, indicated the medication was given 3 times and 2 of the 3 times the medication was effective. On 09/04/14, the psychiatric nurse practitioner evaluated Resident #91. The evaluation indicated the resident was agitated and restless during the evaluation, had a urinary tract infection and was being treated with an antibiotic, and had "poor results" when given Ativan. The nurse practitioner ordered Klonopin, an antianxiety medication, 0.5 mg twice a day for anxiety and agitation. The Ativan was discontinued, and Lexapro , an antidepressant, 10 mg was ordered daily for anxiety /agitation. During an interview on 10/14/2014 10:46 A.M., the DON (Director of Nursing) indicated although the Ativan was helpful, he thought the nurse practitioner ordered the routine Klonopin in an attempt to stabilize Resident #91's mood so she was not having such "roller coaster" bouts of anxiety.		option for a patient experiencing severe anxiety (Attachment H). Resident did show decline in behaviors, however the family felt she was acting too sleepy and requested the klonopin be discontinued 9-12-14. As evidenced by the behavior tracker the resident did begin to have increase in behavior again. Resident was also having acute issues with urinary retention in which she was being followed by the urologist. She has a history of chronic UTIs. Resident remained very hard to redirect or to keep focused on any task. The psych services were consulted again on 10-6-14. At this time it was decided to restart the klonopin and reduce the Seroquel (Attachment I). As evidenced by the behavior tracker, once again we did see a decline in resident behavior. Resident still exhibits anxiety at times but it is much more controlled overall. The facility feels that this medication has not affected any of the resident's functional abilities. Resident is now participating in therapy and walking with restorative. The facility does feel we have consistently addressed all of the medical issues and concerns with resident since her admission. We do feel that the addition of the klonopin originally on 8-21-14 was of benefit to the resident in alleviating	

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	Review of the facility's psychotropic medication use policy and procedure, dated 02/04/08, indicated for anxiolytic medication the targeted behavior were to be clearly identified and monitored. The episodes were to be documented in the clinical record as they occurred along with the results of the interventions used to reduce the behavior or symptoms. The policy also indicated the use of the anxiolytic medication should result in the maintenance or improvement in the individuals mental, physical or psychosocial well being. The policy also indicated the facility was going to assure that medication therapy was based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for psychotropic medication was obtained/received. 3.1-48(a)(6)		her behaviors and anxiety. All medications in the facility are reviewed by the attending pharmacist monthly. All psychoactive meds are reviewed by the behavior team monthly. The facility continues to follow the policy for the administration of psychoactive medications in accordance with the federal guidelines.	
R000000	Miller's Merry Manor of Plymouth was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000		