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 10/10/2014

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: October 6, 7, 8, 9 and 10, 2014. Facility number: 000006 Provider number: 155006 AIM number: 100290220 Survey team: Jason Mench, RN -TC Shelley Reed, RN Angela Selleck RN Census bed type: SNF/NF: 58 Total: 58 Census payor type: Medicare: 4 Medicaid: 48 Other: 6 Total: 58 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by Debora Barth, RN.	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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F000309 SS=E	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 document behaviors and/or lack of behaviors to effectively identify behaviors and/or approaches for behavior management in order to modify and/or revise behavior management plans for 4 of 5 residents with dementia reviewed for unnecessary medications. (Resident #30, #42, #59, #76) Findings include: 1. The clinical record for Resident #30 was reviewed on 10/8/14 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, senile dementia with delusional features, anxiety state and depressive disorder. Resident #30 received the following medications; Risperdal (antipsychotic) 0.5 mg [milligram] daily at 9:00 p.m. and Zoloft (antidepressant) 75 mg daily at	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 #30, #76, #59, and #42 had no adverse effects as a result of this deficient practice. All medications for mood/behavior and the care plans have been reviewed to ensure proper monitoring is in place. All residents receiving medications which require behavior tracking have the potential to be affected by this deficient practice. No negative outcomes have been identified. . All medications for	11/09/2014

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	9:00 a.m. The quarterly Minimum Data Set (MDS) assessment, dated 7/29/14, indicated Resident #30 was severely cognitively impaired. The MDS indicated Resident #30 received an antipsychotic and antidepressant medication 7 days per week. Physical behaviors occurred 1 to 3 days during the MDS assessment. The health care plan, dated 7/8/14, indicated Resident #30 had a problem with behaviors exhibited by: yelling, screaming and cursing. Interventions for the problem included, but were not limited to, "document physical behavior, approach resident in calm manner and take resident for a walk." Review of the "Documentation Survey Report", for the month of July 2014, indicated 31 shifts did not document any behavior and/or lack of behavior. During the month of August 2014, 26 shifts did not document any behavior and/or lack of behavior. During the month of September 2014, 20 shifts did not document any behavior and/or lack of behavior. The month of October 2014, from October 1 through the eighth, had 5 shifts with missing documentation related		mood/behavior and the care plans have been reviewed to ensure proper monitoring is in place. All staff will be re-educated 11-7-14 on the policy for behavior monitoring and documentation. To ensure that that proper behavior monitoring documentation is completed daily the SSD/Designee will complete the QA tool “Behavior and Antipsychotic Medications Review” (Attachment 3) daily x 2 weeks, then 2x weekly x 2 weeks, then weekly x4 weeks and monthly thereafter. Any identified issues will be addressed immediately and logged on the QA Summary Log (Attachment 2). This will be followed and reviewed in the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance. Date of completion: 11-9-14	

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	to behaviors. 2. The clinical record for Resident #76 was reviewed on 10/8/14 at 8:40 a.m. Diagnoses for the resident included but were not limited to, conversion disorder, unspecified psychosis, anxiety, dementia with behavioral disturbances and depressive disorder. Review of the current "Medication Review Report" indicated Resident #76 received the following medications: a. Cymbalta (an antidepressant medication) 30 milligrams by mouth daily at 9:00 a.m. for a diagnosis of conversion disorder. b. Zyprexa (an antipsychotic medication) 10 milligrams by mouth twice daily at 9:00 a.m. and 9:00 p.m. for a diagnoses of conversion disorder and dementia with behaviors. c. Haloperidol Decanoate (an antipsychotic medication) 75 milligrams/milliliter intramuscularly monthly on the 23rd at 1:00 p.m. for a diagnosis of conversion disorder. d. Divalproex Sodium (a mood stabilizer medication) 250 milligrams by mouth twice a day at 6:00 a.m. and 6:00 p.m. for a diagnosis of conversion disorder.			

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	e. Lorazepam (an antianxiety medication) 0.5 milligrams by mouth every eight hours for a diagnosis of anxiety related to medical condition at 6:00 a.m., 2:00 p.m. and 10:00 p.m. The quarterly Minimum Data Set (MDS) assessment, dated 9/16/14, indicated Resident #76 had a moderate cognitive impairment. The health care plan, dated 8/13/14, indicated Resident #76 had a problem with behaviors/mood issues exhibited by the following: "yelling out, excessive worrying and delusions, such as: Thinking people are out to get her." Interventions for the problems included but were not limited to, "Document mood behavior #2: Yelling out... Document mood behavior #1: Delusions/worrying..." The care plan for the problem titled "Behavior" was initiated on 6/13/2014. Review of the "Documentation Survey Report " provided by Director of Nursing (DON) on 10/8/14 at 9:11 a.m., indicated the following: 1. "Document mood behavior #1: Delusions/worrying ..."			

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	a. The month of June 2014 indicated 35 shifts did not document any behavior and/or lack of behavior. b. The month of July 2014 indicated 30 shifts did not document any behaviors and/or lack of behavior. c. The month of August 2014 indicated 28 shifts did not document any behaviors and/or lack of behavior. d. The month of September 2014 indicated 23 shifts did not document any behaviors and/or lack of behavior. e. The month of October 2014, from the first through the seventh, had 3 shifts with missing documentation related to behaviors. 2. "Document mood behavior #2: Yelling out..." a. The month of June 2014 indicated 35 shifts did not document any behavior and/or lack of behavior. b. The month of July 2014 indicated 30 shifts did not document any behaviors and/or lack of behavior. c. The month of August 2014 indicated 28 shifts did not document any behaviors			

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	and/or lack of behavior. d. The month of September 2014 indicated 23 shifts did not document any behaviors and/or lack of behavior. e. The month of October 2014, from the first through the seventh, had 3 shifts with missing documentation related to behaviors. During an interview with the DON on 10/8/14 at 1:40 p.m., she indicated staff were to document each shift whether Resident #76 had a behavior or not. During an interview with CNA #1 on 10/8/14 at 3:31 p.m., she indicated Resident #76 was on behavior monitoring and staff were to document whether a behavior occurred or did not occur on each shift. During an interview with the Social Service Director (SSD) on 10/8/14 at 3:45 p.m., she indicated she was aware of the gaps in the behavior monitoring documentation. The SSD indicated she needed the behavior monitoring documentation for each shift on each day to complete her job. She indicated she could only include information that was documented. The SSD also indicated no behavior monitoring was completed for			

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	Resident #76 when the behaviors were first care planned, from 6/13/14 through 6/21/14. During an interview with the DON on 10/9/14 at 9:05 a.m., she indicated Resident #76 should have been started on behavior monitoring on 6/13/14 the day she came back from an inpatient behavioral unit. 3. The clinical record for Resident #59 was reviewed on 10/9/14 at 9:40 a.m. Diagnoses for the resident included, but were not limited to, depressive disorder and dementia with behavioral disturbances. Review of the current "Medication Review Report" indicated Resident #59 received the following medications: a. Citalopram Hydrobromide (an antidepressant medication) 10 milligrams by mouth daily at 9:00 a.m. for a diagnosis of depression. b. Quetiapine Fumarate (an antipsychotic medication) 12.5 milligrams by mouth daily at 6:00 a.m. for a diagnosis of dementia with behavioral disturbances. c. Quetiapine Fumarate (an antipsychotic medication) 25 milligrams by mouth			

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	daily at 6:00 p.m. for a diagnosis of dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment, dated 9/11/14 indicated Resident #59 was severely cognitively impaired. The health care plan, dated 9/22/14, indicated Resident #59 had a behavior problem. "Resident displays agitation/restless, as exhibited by: hitting/yelling, restless, up [and] down in bed/chair." Interventions for the problem included but were not limited to, "Document physical behavior #2: Hitting/yelling at staff... approach is [in] calm manner and low tones...." The care plan for the problem titled "Behavior" was initiated on 8/21/2013. Review of the "Documentation Survey Report" provided by the Director of Nursing (DON) on 10/8/14 at 9:11 a.m., indicated the following: 1. "Document physical behavior #2: Hitting/yelling at staff..." a. The month of July 2014 indicated 31 shifts did not document any behavior and/or lack of behavior. b. The month of August 2014 indicated			

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	26 shifts did not document any behaviors and/or lack of behavior. c. The month of September 2014 indicated 20 shifts did not document any behaviors and/or lack of behavior. d. The month of October 2014, from the first through the ninth, had 2 shifts with missing documentation related to behaviors. 4. The clinical record of Resident #42 was reviewed on 10/8/14 at 8:40 a.m. The record indicated the resident's diagnoses included, but were not limited to, dementia with delusional features and depression. Resident #42 received the following medication: Seroquel (an antipsychotic medication) 12.5 milligrams (mg) three times a day and Paxil (an antidepressant medication) 10mg daily. The Quarterly Minimum Data Set (MDS) assessment, dated 7/17/14, indicated Resident #42 was severely cognitively impaired. Resident #42's health care plan indicated Resident #42 had a problem with a behavior of paranoid delusions. Symptoms included "resident gets anxious causing her to think others are			

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	doing things against her." Interventions for this behavior included, "reassure resident, listen and activities. Reminisce about family and hobbies. Offer snack, massage and read the Bible. Diversional activities such as fold wash cloths, puzzles and cards." During a review of the "Documentation Survey Report" for Resident #42, the month of July 2014 indicated 35 shifts did not have any documentation concerning any behavior and/or lack of behavior. During the month of August 2014, 27 shifts did not have any documentation concerning any behavior and/or lack of behavior. During the month of September 2014, 15 shifts did not have any documentation concerning any behavior and/or lack of behavior. The month of October 2014, from the first through the eighth, had 7 shifts with missing documentation related to behaviors. During an interview with the Social Service Director (SSD) on 10/9/14 at 9:40 a.m., she indicated the facility was aware of the missing documentation for behavior tracking behaviors and had addressed the issue at the monthly all staff meetings for 3 months. It had been addressed in the Quality Assessment and Assurance Meetings of the last 2 months.			

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	The facility had discussed initiating disciplinary actions on employees not completing their behavior charting as required by policy. During an interview with the Administrator and DON on 10/10/14 at 10:20 a.m., they indicated the QAA committee had addressed the deficient charting practice in relation to behavior tracking charting. This problem was brought up in their all staff in-service meeting 2 months ago and they were not able to fix the problem in that time. The facility had discussed initiating disciplinary actions on staff for not correctly completing the behavior charting. 5. A policy "Behavior Assessment & Management ", dated 4/23/13 and provided by the Director of Nursing (DON) on 10/8/14 at 2:45 p.m., indicated: "1. Purpose: To provide a systematic 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 as they may present a danger to the resident or others, interfere with activities of daily living,			

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	and/or cause the resident distress. The facility will document observation of these behaviors in the clinical record and gather evidence that other possible reasons for the distress or behavior have been considered. To ensure staff respond to residents who exhibit behavioral, mental, physical, or psychosocial symptoms in a dignified manner; and maintain resident quality of life and the safety of the resident and others. 2. New Behavior Assessment Procedure: A. When a new or worsened behavior occurs that may present a danger to the resident or others, interfere with activities of daily living, and/or cause the resident distress the nurse will document the episode on the assessment located in Electronic Medical Record (EMR) titled 'nursing-behavior assessment ....'" 3.1-37(a)			
F000502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview,	F000502	**F502 Administration:** It is the policy	11/09/2014

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	the facility failed to ensure labs were completed for 1 of 5 residents reviewed for unnecessary medications. (Resident #48) Findings include: The clinical record for Resident #48 was reviewed on 10/8/14 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease-stage 4, diabetes mellitus-type 2, and hyperlipidemia. The health care plan, dated 9/19/14, indicated Resident #48 had a problem with hypoglycemia and hyperglycemia. Interventions for the problem included, but were not limited to, "monitor labs as ordered, monitor blood sugars as ordered and monitor meal intakes." Review of the most recent signed physician orders indicated an order for a Glycosylated Hemoglobin (HgbA1C) every 3 months; February, May, August and November. Review of the labs, indicated the August HgbA1C level was 6.7%, elevated above the normal level of 4.5-5.7%. A review of the labs completed for Resident #48, indicated the HgbA1C was not collected during the month of May.		of Miller's Merry Manor, Wabash East that the facility will obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services. Resident # 48 had no adverse effects related to the missed lab draw. The Nurse Practitioner was notified and ordered for the lab to be done in November which would have been the next scheduled draw. All residents receiving laboratory services in the facility have the potential to be affected. All resident records have been reviewed to ensure all ordered lab draws have been completed and are present on the residents' medical records. Nurses will be re-educated on the proper procedure for scheduling/tracking any ordered lab draws on 10-29-14. On 10-29-14 all current processes for lab tracking will be reviewed with staff. To ensure this does not reoccur the DON/Designee will complete the QA audit tool "Laboratory Review" (Attachment 1) weekly on all scheduled and newly ordered lab draws for the next four weeks, then monthly for five months and then quarterly thereafter. Any identified issues will be addressed immediately and logged on the QA Summary Log (Attachment 2	

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	During an interview with the Director of Nursing (DON) on 10/9/14 at 8:10 a.m., she indicated the HgbA1C was not collected during the month of May for Resident #48 as ordered. She indicated the facility had a new process for monitoring laboratory orders and it had recently been included in the Quality Assurance and Assessment (QAA) 3.1-49(a)		). This will be followed and reviewed in the monthly facility Quality Assurance Performance Improvement meeting to ensure ongoing compliance. Date of completion: 11-9-14	