

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155556	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FAIRGROUNDS RD TIPTON, IN 46072
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F000000	<p>This visit was for the Investigation of Complaint #IN00132203.</p> <p>Complaint #IN00132203-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309</p> <p>Survey dates: July 16, 17, & 18, 2013</p> <p>Facility number: 000505 Provider number: 155556 AIM number: 100266350</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: SNF: 18 SNF/NF: 104 Total: 122</p> <p>Census Payor type: Medicare: 20 Medicaid: 80 Other: 22 Total: 122</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>Please accept the following plans of correction as credible allegation of compliance for each deficiency cited during the complaint survey conducted here on July 18th, 2013. Should you have any questions or require further information, please do not hesitate to contact me here at the facility at 765-675-8791. Additionally, the facility respectfully asks that paper compliance be considered. Sincerely, Troy Clements, Administrator</p>	
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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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	IAC 16.2. Quality Review was completed by Tammy Alley RN on July 24, 2013.			
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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of a medication change and lab results for a resident receiving hospice services,</p>	F000157	<p>F157</p> <p>Please accept the following credible</p>	08/07/2013

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	<p>for 1 of 6 reviewed for physician notification in a sample of 6. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on July 17, 2013, at 9:50 a.m.</p> <p>Diagnoses for Resident B included, but were not limited to, amyotrophic lateral sclerosis (ALS), high blood pressure, depressive disorder, history of prostate cancer, and coronary artery disease.</p> <p>Nursing progress notes, dated 6/23/13, at 12:04 p.m., indicated Resident B was confused and delusional. Family, MD (physician) and hospice were aware.</p> <p>A physician's order, dated 6/23/13, at 12:00 p.m., indicated the following, "UA [urinalysis] with C & S [culture and sensitivity], if indicated related to confusion."</p> <p>During an interview with the Director of Nursing (DON), on 7/17/13, at 2:00 p.m., she indicated the primary physician was called regarding Resident B's confusion. When the UA results were received on 6/23/13,</p>		<p>allegation of compliance to the deficient practice cited under tag F157, of which ALL residents had the potential to be affected by.</p> <p>It is the Policy of Miller's Merry Manor-Tipton that any change in condition, new orders, or abnormal lab results are communicated to the ordering MD, the Primary MD, and the responsible party. It is also our policy that all labs are collected in a timely manner, results are obtained in a timely manner and any abnormal results are communicated to the ordering MD, the Primary MD, and the responsible party. When a resident is on Hospice services and show a change in condition it is our policy that the facility is responsible for notifying the Hospice service first, then the Primary MD and responsible party. The facility is also responsible for notifying the Primary MD and responsible party for any new orders obtained from the Hospice MD.</p> <p>To correct the deficient practice all nurses will be in-serviced on 8/7/13. The in-service will include overview of the Policy titled "Physician and Family Notification of Condition Change" (Attachment 1a). The in-service will also cover Hospice residents and the communication</p>		

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	<p>the primary physician was contacted with the results.</p> <p>A physician's order, dated 6/23/13, at 9:30 p.m., indicated an order for Cipro (antibiotic), 500 mg. (milligrams), bid (twice daily), for 7 days, for a UTI (urinary tract infection).</p> <p>A physician's order, dated 6/26/13, at 10:30 a.m., stated D/C (discontinue) Cipro.</p> <p>During an interview with Resident B's primary physician on 7/17/13 at 4:15 p.m., she indicated she was not aware Cipro was discontinued for Resident B because she did not order it. Furthermore, she indicated she did not receive any correspondence related to Resident B for the week of 6/24/13, from the facility or hospice services.</p> <p>During an interview with the DON, on 7/17/13, at 2:00 p.m., she indicated the primary physician was not aware of C & S results because the results were not received until after Resident B expired. Resident B expired 6/29/13. The facility did not have C & S results until 7/10/13. The C & S results report indicated the final results were dated 6/26/13.</p>		<p>methods that must take place and documented when a change of condition is noted, new orders are obtained, or abnormal lab results are obtained. The DON also met with the lab director (Mary Anne), on 7/21/13; this meeting was to discuss lab results that were not obtained in a timely manner. To correct this deficient practice all labs will be automatically faxed from the diagnostic center to the facility. This will eliminate the "middle man" system that were using; in the past the lab techs would hand deliver the results.</p> <p>For continued compliance the "Hospice/MD Notification" QA Tool (Attachment 1b) and the "Laboratory Review" QA tool (Attachment 1c) will be completed daily x 2 weeks, weekly x 4 weeks, monthly x 3 months, and quarterly thereafter. Any issues will be corrected immediately, recorded on a facility QA Tracking Log and reviewed in the facility QA Meeting monthly with any new recommendations implemented. These corrective actions will be completed by 8/7/13.</p>				

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	This Federal tag relates to the Complaint IN00132203. 3.1-5(a)(3)				

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F000309 SS=D	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure services were completely coordinated between the facility and hospice services, failed to obtain lab results, and failed to follow a hospice care plan for 1 of 6 residents reviewed for hospice services and thorough follow through for lab orders, in a sample of 6. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on July 17, 2013 at 9:50 a.m.</p> <p>Diagnoses for Resident B included, but were not limited to, amyotrophic lateral sclerosis (ALS), high blood pressure, depressive disorder, history of prostate cancer, and coronary artery disease.</p> <p>Resident B entered a contract to receive hospice services on 4/9/13, as indicated on a hospice agreement</p>	F000309	<p>F309</p> <p>Please accept the following credible allegation of compliance to the deficient practice cited under tag F309, of which ALL residents had the potential to be affected by.</p> <p>It is the Policy of Miller's Merry Manor-Tipton that any change in condition, new orders, or abnormal lab values are communicated to the ordering MD, the Primary MD, and the responsible party. When a resident is on Hospice services and show a change in condition it is our policy that the facility is responsible for notifying the Hospice service first, then the Primary MD and responsible party. The facility is also responsible for notifying the Primary MD and responsible party for any new orders obtained from the Hospice MD.</p>	08/07/2013	

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	<p>form, signed by Resident B's power of attorney (POA).</p> <p>The hospice agreement, under "Plan of Care", stated:</p> <p>"b. At the time a Facility resident is admitted to the Hospice program, Hospice shall coordinate with Facility in the admission process and the development and implementation of the patient's Plan of Care. The parties will collaborate in jointly coordinating the implementation, evaluation and modification, as needed, of the Plan of Care on an ongoing basis."</p> <p>"d. Hospice and Facility shall each immediately notify the other of any change in the condition or symptoms of a Hospice Patient that requires a change in the patient's Plan of Care."</p> <p>1. Nursing progress notes, dated 6/23/13, at 12:04 p.m., indicated Resident B was confused and delusional. Family, MD (physician) and hospice were aware.</p> <p>A physician's order, dated 6/23/13, at 12:00 p.m., indicated the following, "UA [urinalysis] with C & S [culture and sensitivity], if indicated related to confusion."</p>		<p>To correct the deficient practice all nurses will be in-serviced on 8/7/13. The in-service will include overview of the Policy titled "Physician and Family Notification of Condition Change" (Attachment 1a). The in-service will also cover Hospice residents and the communication methods that must take place and documented when a change of condition is noted, new orders are obtained, or abnormal lab results are obtained. Such as; if a resident is on hospice, all changes in condition will be reported to the Hospice service, then the Primary MD and responsible party. If new orders are obtained from the Hospice, it is the facility's responsibility to notify the Primary MD and responsible party.</p> <p>For continued compliance the "Hospice/MD Notification" QA Tool (Attachment 1b) will be completed daily x 2 weeks, weekly x 4 weeks, monthly x 3 months, and quarterly thereafter. Any issues will be corrected immediately, recorded on a facility QA Tracking Log and reviewed in the facility QA Meeting monthly with any new recommendations implemented. These corrective actions will be completed by 8/7/13.</p>				

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	<p>During an interview with the Director of Nursing (DON), on 7/17/13, at 2:00 p.m., she indicated the primary physician was called regarding Resident B's confusion. When the UA results were received on 6/23/13, the primary physician was contacted with the results.</p> <p>A physician's order, dated 6/23/13, at 9:30 p.m., indicated an order for Cipro (antibiotic), 500 mg. (milligrams), bid (twice daily), for 7 days, for a UTI (urinary tract infection).</p> <p>A physician's order, dated 6/26/13, at 10:30 a.m., stated D/C (discontinue) Cipro.</p> <p>Documentation related to hospice notification of Resident B's condition change, the ordered antibiotic, and the discontinuation of the ordered antibiotic were not evident. During an interview with the DON, on 7/17/13, at 2:00 p.m., she indicated there was a lack of documentation.</p> <p>During an interview with the Unit Manager, on 7/18/13 at 10:35 a.m., she indicated she received an order, from the hospice case manager for Resident B, to discontinue the use of Cipro on 6/26/13.</p>			
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	<p>During an interview on 7/18/13, at 11:00 a.m., with Resident B's hospice case manager, she indicated she received a call from a facility nurse (name not remembered) on 6/27/13. The facility nurse told her Resident B had an order for Cipro due to UA results. The case manager explained she said to the nurse, "Why would you start an antibiotic for an UTI (urinary tract infection) without C & S results? You can't be sure of an UTI without C & S results."</p> <p>She, the case manager, further indicated, the next day, 6/28/13, she received a phone call from the unit manager (UM). The UM indicated the facility discontinued the Cipro due to improper collection of the urine sample and because the C & S results were not received, yet. The case manager indicated as far as she knew, she did not know if Resident B ever received Cipro or not.</p> <p>During an interview with Resident B's primary physician on 7/17/13 at 4:15 p.m., she indicated she was not aware Cipro was discontinued for Resident B because she did not order it. Furthermore, she indicated she did not receive any correspondence related to Resident B for the week of</p>			
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	<p>6/24/13, from the facility or hospice services.</p> <p>During interviews with facility nurses, various replies were given regarding who to contact in the event a resident receiving hospice services had a change in condition. The following replies were as follows:</p> <p>On 7/17/13, at 2:45 a.m., during an interview with Nurse #1, she indicated call hospice, only, hospice would call the doctor and the family.</p> <p>Nurse #2 indicated, on 7/17/13 at 2:53 p.m., call hospice and hospice will contact the doctor and family. However, if no response was received from hospice, call the primary physician. The written orders should reflect which physician ordered the treatment.</p> <p>During an interview with Nurse #3, on 7/17/13, at 3:00 p.m., she indicated call hospice.</p> <p>Nurse #4 indicated call the primary physician, first, then call hospice, and then call the family, during an interview on 7/17/13 at 3:05 p.m.</p> <p>On 7/17/13, at 3:15 p.m., Nurse #5 indicated call hospice. On the</p>			

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	<p>physician's order, write the hospice physician name, then write "for", then write the primary physician's name.</p> <p>During an interview on 7/17/13, at 11:45 a.m., Nurse #6 stated she only worked weekends. She indicated that she and another weekend nurse were not sure who to contact in the event of a condition change for a hospice resident. Therefore, when Resident B's confusion increased, the nurse called the primary physician, only.</p> <p>The DON indicated communication between the facility staff and the hospice service staff was based on coordination between the two at the time of any given discussion, during an interview on 7/17/13 at 2:00 p.m. She indicated she expected facility nurses to contact hospice services in the event of a resident's condition change/concern.</p> <p>2. Evidence of C & S results shared with the ordering primary physician were not available.</p> <p>During an interview with the DON, on 7/17/13, at 2:00 p.m., she indicated the primary physician was not notified of C & S results because the results were not received until after Resident B expired. Resident B expired</p>						

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	<p>6/29/13. The facility did not have C & S results until 7/10/13. The C & S results report indicated the final results were dated 6/26/13. The DON indicated facility staff did not thoroughly follow up on C & S results.</p> <p>3. A facility care plan for hospice services, originally dated 4/9/13, indicated "Resident will be followed by hospice care."</p> <p>Intervention #6 stated, "Staff nurses will contact hospice with information that affects resident care."</p> <p>Nursing progress notes, dated 6/23/13, at 12:04 p.m., indicated the resident was confused and delusional. The primary physician was contacted.</p> <p>During an interview on 7/17/13, at 11:45 a.m., Nurse #6 indicated when Resident B's confusion increased, the nurse called the primary physician, only.</p> <p>This Federal tag relates to the Complaint IN00132203.</p> <p>3.1-37(a)</p>			

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