

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: June 11, 12, 13, 14, 17, 18, and 19, 2013</p> <p>Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980</p> <p>Survey team: Julie Wagoner RN, TC Deb Kammeyer RN Lora Swanson RN</p> <p>Census Bed type: SNF: 19 SNF/NF: 101 Total: 120</p> <p>Census Payor type: Medicare: 16 Medicaid: 81 Other: 23 Total: 120</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 26, 2013, by Brenda Meredith, R.N.</p>	F000000	<p>This facility respectfully requests consideration for Paper Compliance for this plan of correction. Please accept this plan of correction as our credible allegation of compliance.</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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F000250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview, observation and clinical record, the facility failed to distinguish between the type of a behavior a resident was experiencing and the type of individualized intervention provided in 7 of 10 residents reviewed for monitoring of medications. (Resident #2, #7, #31, #51, #127, #130, and #143)</p> <p>Findings included:</p> <p>1. The clinical record for Resident #7 was reviewed on 6-14-13 at 3:00 p.m. The resident's diagnoses included, but were not limited to: dementia without behavioral disturbance, hypertension, hypothyroidism, atrial fibrillation, congestive heart failure, gout, depressive disorder, and anxiety state.</p> <p>The Careplan was reviewed and indicated the resident had the potential to experience depression symptoms and ineffective coping (agitation, crying, anxiousness and restlessness). The interventions included but were not limited to:</p>	F000250	<p>It is the policy of Miller's Merry Manor, Wakarusa, to provide medically related social services to attain or maintain the highest physical, mental, & psychosocial well being of each resident. Residents 2, 7, 31, 51, 127, 130 & 143: The care plan team will assess each resident for behavioral symptoms or patterns & will revise or update each plan of care as needed to ensure psychosocial needs of the residents are met by 7/19/13. Each resident's behavior plan & specific interventions will be re-evaluated as needed & added to the plan of care & behavior monitoring program. Resident specific behavior plans & interventions will be communicated to the nursing staff via the nursing assignment sheet. Documentation of behavior episodes & the effectiveness of individualized interventions will be documented in the electronic medical record for each resident. All residents whose medication regimen includes psychoactive/psychopharmacological medications to treat behavioral/mood symptoms are at risk to be affected by this deficient practice. The facility</p>	07/19/2013			

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	<p>encourage resident to express feelings, medication as ordered, provide reassurance and help resident to cope using past successful coping mechanisms.</p> <p>An observation of the resident in her room was made on 6-13-13 at 10:07 a.m. The resident was sitting in her recliner dressed, with the television on. The resident's room was clean and items organized. The resident was calm and able to voice her concerns, questions, and compliments regarding her care at the facility during stage one interview.</p> <p>On 6-17-13 at 9:05 a.m. a review of the physician orders indicated the Resident had a dose reduction on 3-14-12 from Ativan 0.5 mg (milligrams) four times a day (QID) to Ativan 0.25 mg three times a day (TID), then on 3-23-13 Ativan was discontinued. On 3-31-12, Ativan 0.25 mg QID was ordered for increased behaviors. Celexa was started 12-2-11, for depression.</p> <p>On 6-17-13 at 9:25 a.m. the form titled "intervention/task" for June and May 2013 used to monitor behaviors was reviewed. The form indicated behaviors occurred 1 day in June and 7 days in May. The monitoring did</p>		<p>nurse managers & social service staff will complete a behavior plan audit on all residents who are prescribed psychopharmacological/psychoactive medications by 7/19/13. Each resident's medication regimen will be reviewed to ensure proper diagnosis/indication for ongoing use of psychopharmacological/psychoactive medications. Residents who display behavioral symptoms/mood issues will have their plan of care reviewed & will have resident specific interventions that assist to reduce/prevent the occurrence identified. An all nursing staff in-service will be held on or before 7/19/13 to review the facility policies for "Behavior Management Assessment/Program" & "Psychotropic Drug Use". The in-service will include an assessment of behavior symptoms, including the definition, process for documenting new or ongoing behavioral symptoms, resident specific interventions, & documenting in the electronic medical record. An emphasis on ensuring proper indication or diagnosis prior to any initiation of psychotropic medication will be reviewed. The facility behavioral committee will continue to meet monthly to monitor the effectiveness of interventions & the need to change or modify</p>				

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	<p>not distinguish between what behavior the resident was having and what interventions was successful.</p> <p>An interview with Social Service Director, on 6-17-13 at 1:50 p.m., indicated the computer system doesn't have the capability to distinguish between what behavior the resident was having and what interventions helped to decrease the behaviors. The Social Service Director further explained that the interventions documented in the computer were nonpharmacological.</p> <p>An interview with CNA #2, on 6-18-13 at 10:45 a.m., indicated the behaviors a resident experiences were documented in the computer. She indicated a behavior question was included in her daily charting. CNA #2 could answer "yes" or "no" to indicate if the resident had a behavior. When asked if she could chart which intervention she used she indicated the computer doesn't give her that option. CNA #2 further indicated behavior interventions are not on her CNA worksheet and that she could view interventions on the computer when she was charting for the day. CNA #2 indicated she uses "whatever intervention works" at time of the situation.</p>		<p>behavior programs to ensure psychosocial needs are met for each resident on an ongoing basis. The behavior tracking sheets, side effect monitoring sheets, & interviews with staff/residents will be utilized to evaluate resident specific behavioral plans during the monthly review.</p> <p>The nursing assignment sheets will serve as the communication tool for nursing assistants regarding which resident has a behavior program & individualized resident specific interventions to use during care. Charge nurses will be instructed to document any significant change in status resulting in a new onset of behaviors, or worsening of behaviors, on the 24 hour condition report. The 24 hour condition report is routinely reviewed by the nurse managers to ensure significant changes in condition are readily addressed by members of the health care plan team & to prevent the use of unnecessary medications. The Social Services Director, or designee, will be responsible to complete the Quality Assurance tool titled "Behavior and Antipsychotic Medication Review" (Attachment A) on 10 residents weekly for 4 weeks, then 10 residents monthly thereafter, to monitor for compliance. This system for monitoring will be reviewed during the monthly Quality Assurance</p>		

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	<p>2. An observation of the Resident #143 was completed on 6-13-13 at 9:13 a.m. in her room. The resident was sitting in a chair, dressed and listening to the radio with a magazine in her lap. She was interviewable and answered questions without difficulty.</p> <p>The clinical record for Resident #143 was reviewed on 6-14-13 at 2:00 p.m. The resident's diagnoses included, but were not limited to: atrial fibrillation, depressive disorder, hypertension dementia with lewy bodies, insomnia, dementia with behavioral disturbances, congestive heart failure, esophageal reflux and anxiety state. The resident was on Restoril 7.5 mg (a sedative-hypnotic medication) and Xanax 0.125 mg daily (an antianxiety medication).</p> <p>On 6-14-13 at 2:15 p.m., the Careplan's were reviewed and indicated the resident displays mood issues, behaviors as exhibited by: screaming/yelling/swearing, disruptive noises, excessive nervousness, restlessness, wringing hands, excessive worrying, excessive crying, tearfulness. Interventions included but were not limited to: administer psych medication as ordered, no adverse side effects from medication,</p>		meeting & any findings will be corrected & logged on a Quality Assurance summary log to monitor for compliance.				

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	<p>anxiety will not cause distress, offer reassurance in calm voice, and decrease stimulation.</p> <p>On 6-14-13 at 2 25 p.m., a form titled "intervention/task" for June and May 2013, was reviewed. The form was used to monitor behaviors and indicated behaviors occurred 6 times in June. The monitoring did not distinguish between what behavior the resident was having and what interventions was successful.</p> <p>An interview with the Social Service Director on 6-17-13 at 1:50 p.m., indicated that computer system doesn't have the capability to distinguish between what behavior the resident was having and what interventions helped to decrease the behaviors.</p> <p>An interview with CNA #2 on 6-18-13 at 10:45 am indicated that behavior are documented in the computer. She indicated a behavior question was included in her daily charting. CNA #2 further explained could chose "yes" or "no" to indicate if the resident had a behavior. When asked if she could document which intervention she used, the CNA indicated the computer doesn't give her that option. CNA #2 further indicated that</p>						

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	<p>behavior interventions are not on her CNA worksheet and that she could view interventions on the computer when she was charting for the day. CNA #2 indicated she uses "whatever intervention works" at time of the situation.</p> <p>On 7-19-13 at 9:45 a.m. a review of the policy titled "Psychotropic Medication Use" undated indicated on line 2 under procedure paragraph "...On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the results..."to cause distress, offer reassurance in calm voice, calm surroundings, decrease stimulation, and document mood behavior.</p> <p>3. The clinical record for Resident #127 was reviewed on 6-14-13 at 3:30 p.m. The resident's diagnoses included, but were not limited to: diabetes type II, Alzheimer' disease, dementia, hypertension, anxiety state, depressive disorder, restless legs syndrome, esophageal reflux, neurogenic bladder, congestive heart failure, chronic pain and obesity.</p> <p>A review of the Medication Administration Record on 6-14-13 at 3:45 p.m., indicated the was taking</p>			

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	<p>the following medications: Lexapro (antidepressant), and Xanax (antianxiety).</p> <p>On 6-14-13 at 3:50 p.m., review of the behavior sheets titled "Intervention/Task" indicated the resident had 6 behaviors in the month of June, with 5 occurring on second shift. The behavior sheet indicated that for 2 days the intervention outcome was "unchanged." The behavior sheet did not indicate what interventions had been attempted that left the resident "unchanged."</p> <p>An interview with the Social Service Director on 6-17-13 at 1:50 p.m., indicated the computer system doesn't have the capability to distinguish between what behavior the resident was having and what interventions helped to decrease the behaviors. The Social Service Director further indicated if there would be a pattern of unchanged outcomes, the team would discuss possible need to change the interventions. The CNA's are given three responses to document outcome of the interventions to reduce or redirect the resident's behavior which include: improve, unchanged or response not required.</p>			

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	<p>On 6-18-13 at 11:20 a.m. an interview with CNA #3 on ICF referred to a book titled "ICF Care plans/Behaviors". She indicated that the book listed behaviors and interventions. CNA indicated she charts in the computer and book is a reference to what behaviors a resident may have and interventions to use for the resident that was having a behavior. CNA #3 further indicated she could not document in the computer which interventions were used only that behavior improved or was unchanged.</p> <p>4. The clinical record for Resident #130 was reviewed on 6-17-13 at 9:30 a.m. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbances, depressive disorder, atrial fibrillation, asthma, congestive heart failure, chronic airway obstruction, hypertension, anemia, and chronic kidney disease.</p> <p>Review of a history and physical report from an August 2012 hospitalization indicated there was an inpatient due to behaviors (agitation) and was started on Risperdal 0.25 mg BID.</p>				

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	<p>On 6-17-13 at 9:50 a.m. the gradual dose reductions were reviewed, In January of 2013 Risperdal an antipsychotic medication was decreased at pharmacy recommendation from Risperdal 0.25 mg BID (twice a day) to Risperdal 0.25 mg at bed time and 0.25 mg every am except Thursdays (omit Thursdays dose).</p> <p>The Careplan's were reviewed and indicated the resident has potential for signs and symptoms of depression related to: loss of independence and decline in health. Interventions included but were not limited to: resident will exhibit no signs & symptoms of mood decline, monitor side effects at least daily on psychotropic medication record, and provide support and encouragement as needed. Another Careplan indicated the resident had behaviors/mood issues exhibited by: restlessness, wringing hands, excessive worrying, excessive crying, and tearfulness. Interventions included but were no limited to: anxiety will not cause distress, monitor medication side effects at least daily on psychotropic medication record, and document mood behavior: restlessness, wringing hands, excessive worrying, excessive</p>						

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	<p>crying, and tearfulness.</p> <p>An interview with CNA #2 on 6-18-13 at 10:45 am indicated that behaviors were documented in the computer. CNA #2 indicated she uses "whatever intervention works" at time of the situation and she cannot document what intervention specifically she used for a behavior.</p> <p>5. On 6/17/13 at 8:47 A.M., record review indicated Resident # 31's diagnoses included, but were not limited to, "...peripheral vascular disease, hypertension, chronic kidney disease, depressive disorder, dementia, diabetes type II and cardiac dysrhythmias...." Review of the psychotropic administration record indicates Resident #31 has ordered Seroquel 12.5 mg one tab twice daily for dementia with behavior disturbances.</p> <p>On 6/17/13 at 10:53 A.M., review of the behavior care plan, dated 10/17/2011, indicated "... resident displays inappropriate physical behavioral issues as exhibited by: hitting, kicking and pinching staff during care. Interventions...Document physical behavior: hitting, kicking and pinching staff during care. 1. Approach calmly with friendly smile.</p>				

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	<p>2. Explain task and allow time to process. 3. Give diversional task such as holding a wash cloth. 4. Leave safely and reapproach...."</p> <p>On 6/18/13 at 8:46 A.M., review of the behavior tracking log indicated no behaviors for March 2013. On 4/14/13 at 2125 (9:25 P.M.), it was indicated a behavior occurred and the behavior was unchanged after the intervention. On 4/18/13 at 0659 (6:59 A.M.), it was indicated a behavior occurred and the behavior improved after the intervention. In May 2013, it was documented on 4 different dates that a behavior occurred and the behavior improved after the intervention. On 5/22/13, a behavior occurred and the behavior was unchanged after the intervention. In June 2013, it was indicated that a behavior occurred 2 times and the behavior was improved after the intervention. It was not indicated on the behavior log which behavior occurred, or which intervention was successful or unsuccessful.</p> <p>On 6/18/13 at 9:15 A.M., an interview with the Social Service Director indicated before a staff member marks that a behavior was unchanged on the behavior tracking log they are to try all of the</p>						

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	<p>interventions listed. If the staff mark improved that means they stopped after the first successful intervention. Usually the nurses do not document behaviors in the nurse progress notes to avoid double documentation. If I see that staff are marking behaviors as unchanged I will interview them to find out what is not working so I can change the interventions.</p> <p>On 6/18/13 at 10:17 A.M., during observation of resident care using a Hoyer lift to get resident up out of bed no behaviors were observed.</p> <p>On 6/18/13 at 10:20 A.M., an interview with Employee #4 indicated Resident #31 has not had any behaviors with care for a long time. Once in a while I will see her swat at the nurses hand when she gets an insulin shot but that is all I have seen.</p> <p>On 6/19/13 at 9:15 A.M., review of the current policy titled "Psychotropic Medication Use" received from the Administrator indicated "...non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication...On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to</p>				

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	<p>reduce and the results...."</p> <p>6. The clinical record for Resident #2 was reviewed on 06/17/13 at 9:30 A.M. Resident #2 was admitted to the facility on 01/04/13 with diagnosis, including but not limited to, epilepsy, hypertension, chronic ischemic heart disease arthropathy, dementia with behavioral disturbances, macular degeneration of retina, and insomnia.</p> <p>On 06/14/13 at 10:15 A.M., Resident #2 was observed in bed asleep.</p> <p>On 06/14/13 at 1:35 P.M., Resident #2 was observed in a wheelchair at a table in the circular resident lounge outside of his room, his eyes were closed, he would occasionally moan. There were newspaper ads on the table in front of him, but the resident kept his eyes closed and was noted to be fiddling with his pant legs.</p> <p>On 06/17/13 at 9:10 A.M., Resident #2 was observed seated in high back wheelchair in circular lounge outside his room, asleep. The resident's top dentures were partially hanging out of his mouth.</p> <p>On 06/17/13 at 9:30 A.M., Resident #2 was transferred from his wheelchair to his bed by two CNA's</p>						

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	<p>with a mechanical lift. Resident #2 did stir a bit with the movement, but kept eyes closed and did not exhibit any behavior issues.</p> <p>On 06/17/13 at 11:20 A.M., Resident #2 was observed being pushed in his wheelchair from his room to the circular lounge outside his room. The resident was noted to be awake and calm.</p> <p>The resident's current medication regimen for June 2013, included the antipsychotic medication, Risperdal 1.0 mg three times a day for "restlessness and behavior" and the natural supplement Melatonin 3 mg at bedtime for insomnia. In April 2013, an antianxiety medication and an antipsychotic medication were discontinued and the antipsychotic medication, Risperdal was initiated. On 04/29/13, the Risperdal medication was increased and a pain medication was made routine.</p> <p>The current care plans for Resident #2, last reviewed on 05/13/13, regarding behaviors, indicated the resident plan to address the resident's mood issues as exhibited by screaming/yelling/swearing, disruptive noises, excessive nervousness, restlessness, and excessive worrying.</p>			

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	<p>The interventions to the plan included: "Administer psych medication as ordered., Monitor medication side effects at least daily on psychotropic medication record., Notify physician as needed., Listen to concerns and follow-up on these promptly as needed., and Provide support and encouragement PRN."</p> <p>There was also a plan to address the resident's insomnia and the interventions included: "Administer medications as ordered., Notify physician if medications are not effective. Assess for pain., Encourage adequate exercise during the day and discourage napping., and Encourage resident to limit caffeine containing products during the day and try to eliminate after supper time."</p> <p>The Behavior monitoring form for Resident #2 indicated the facility was to: · "Document mood behavior #1:screaming/yelling/swearing, disruptive noises, excessive nervousness, restlessness, Interventions:[1] Assess for unmet needs [2] Provide gental reassurance [3]diversional activity, TV room/birds [4]Calm surroundings and music."</p>						

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	<p>Interview with SSD, on 06/17/13 at 10:47 A.M., indicated the resident had changed and had previously been on antipsychotics and they were just trying to figure out what was going to work with him.</p> <p>Review of the behavior tracking forms for Resident #2 for April, May, and June 2013, indicated the number of shifts the resident had mood behavior issues had decreased in May and June 2013. In addition, the interventions improved the resident's behaviors. However, it was unclear how often per shift the resident had behaviors, which intervention had been attempted, and which intervention had been successful.</p> <p>7. The clinical record for Resident #51 was reviewed on 06/17/13 at 11:00 A.M. Resident #51 was admitted to the facility on 07/17/09, with diagnoses, including but not limited to insomnia, tear film insufficiency, anemia, diabetes, congenital anomaly of the heart, Alzheimer's disease, dementia, dizziness, osteoarthritis, and hypertension.</p> <p>Resident #51 was observed, on 06/14/13 at 1:44 P.M., seated in wheelchair in pod, anxious and</p>						

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	<p>weepy, talking repeatedly about her Dad and being lost and losing some of her belongings. Resident #51 was noted to continue the behavior for at least 10 minutes. Although staff were nearby the resident, staff did not intervene or respond to Resident #51. At 1:54 P.M., staff were alerted to the resident's distress and the resident was noted to stop weeping momentarily and was less distressed when she was interrupted with conversation. The resident could answer a few basic questions but would then go back to weeping and anxious repetitive verbalizations when not given 1:1 conversation. At one point, a staff member pushed Resident #51 to an exit door to look outside.</p> <p>Resident #51 was observed, on 06/17/13 from 1:30 - 2:45 P.M., seated in her room in a wheelchair. The resident was noted to be constantly speaking to her "Daddy" and intermittently weepy and distressed with the behavior. At 2:45 P.M., CNA #5 indicated the resident often was delusional with her speaking but would stop and converse when spoken to for short periods of time.</p> <p>Resident #51 was observed, on</p>				

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	<p>06/18/13 at 1:30 P.M., seated in her wheelchair in the lounge. The resident was delusional having a conversation with her deceased mother and father. RN #5 interrupted her and asked her about one of the statements she had been making with her parents and the resident elaborated on the statement about buying shoes. The resident was less weepy and disturbed about her conversations. The resident stopped the delusional conversation when a nursing staff member took her to her room. The resident was smiling and content. She was go noted to go back to the delusional conversation when she was not engaged in conversation or an activity.</p> <p>The current physician's orders for Resident #51 included the antipsychotic medication, Risperdal .25 mg twice a day, the antianxiety medication, Ativan .5 mg four times a day, and the hypnotic medication, Ambien 5 mg at bedtime for insomnia.</p> <p>The current health care plan for June 2013, regarding behaviors for Resident #51, indicated the resident displayed "mood behavior" exhibited by "excessive nervousness, restlessness, wringing hands, excessive drying, and tearfulness,</p>						

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	<p>and delusions, such as believes she is waiting on tour bus, or she is going to a wedding, or believes she is pregnant. The interventions included: assess for unmet needs, diversion, conversation, talk about what she brings up or other things such as the weather, cup of cocoa, do not argue or attempt to reason, and assist to new environment.</p> <p>Interview with SSD, on 06/18/13 at 2:30 P.M., indicated the CNA's documented behaviors per shift, one documentation no matter how many times the behavior occurred during their shift. In addition, she indicated the CNA's documented if the behavior improved or were unchanged as they were to attempt all of the interventions . The SSD could not tell how many specific episodes of behaviors had occurred per shift and could not tell which specific intervention might have been helpful and which interventions were ineffective with the current documentation. The SSD indicated she tried to observe the residents with behaviors and talk with the staff also .The SSD, on 06/17/13, at 9:30 A.M., indicated Resident #51 was hard to talk with due to her having simultaneous conversations with other delusional people. She</p>						

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	<p>indicated at times decreasing the stimuli was the best thing for the resident.</p> <p>The behavior management plan had not been updated since 04/01/13, even though the resident was observed on three consecutive days in June with behavior issues.</p> <p>3.1-34(a)</p>				

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F000323 SS=D	<p>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 provide a proper fitting mattress for the bed frame to reduce the risk of entrapment for 1 of 1 residents reviewed for accidents. (Resident # 31)</p> <p>Findings include:</p> <p>On 6/14/13 at 1:00 P.M., record review indicated Resident # 31's diagnoses included, but were not limited to "...peripheral vascular disease, hypertension, chronic kidney disease, depressive disorder, dementia, diabetes type II and cardiac dysrhythmias...."</p> <p>Review of the quarterly MDS (Minimum Data Set) assessment, completed on 5/1/13, assessed Resident #31 as requiring extensive assist for bed mobility.</p> <p>On 6/14/13 at 9:30 A.M., Resident #31 was observed resting in bed, the head of the bed was flat. The top of</p>	F000323	It is the policy of Miller's Merry Manor, Wakarusa, to ensure that the resident environment remains as free from accident hazards as possible & that each resident receives adequate supervision to prevent accidents. Resident 31 did not experience any negative outcomes related to this deficient practice. All facility residents were potentially at risk to be affected by this deficient practice. The Maintenance Supervisor & Administrator were made aware of this issue by the Survey Team on 6/14/13. We immediately installed a spacer cushion in between the mattress & footboard of the bed for Resident 31, which eliminated the concern related to Resident 31. The Maintenance Dept. immediately made walking rounds to look at every other bed in the facility to ensure proper placement of mattresses to the bed frames & found no other issues. All staff members will be inserviced on or before 7/19/13 re: the use of spacer cushions & proper positioning of mattresses on bed frames. Staff will be educated that the use of a spacer cushion is permitted &	07/19/2013

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	<p>the mattress was pushed up and touching the head board. The gap at the foot of the bed measured 5 1/2 inches. No bolster or blanket was observed at the foot of the bed.</p> <p>On 6/14/13 at 9:40 A.M., Employee #1 measured the mattress for Resident #31 and indicated the gap at the foot of the bed was 5 1/2 inches.</p> <p>On 6/14/13 at 9:45 A.M., an interview with Employee #1 indicated he thinks the space at the head and the foot of the bed should be less than 4 inches.</p> <p>On 6/17/13 at 11:20 A.M., record review of the current policy titled "Specialty Mattress Use" received from the Assistant Director of Nursing indicated "...Check that the mattress fits properly on the bed frame, assess for any gaps and place spacers as needed...."</p> <p>3.1-45(a)(1)</p>		<p>that spacer cushions should not be removed & only placed at the foot end of the bed. The Maintenance Dept. will be responsible to ensure that new mattresses are properly installed & fitted to bed frames prior to resident use. The Maintenance Supervisor, or designee, will make weekly walking rounds for 4 weeks, then monthly thereafter, to monitor every mattress & bed frame for properly fitting mattresses. The Quality Assurance tool titled "General Facility Observation of Facility Review" (Attachment B) will be utilized. Any identified issues will be immediately corrected & documented on a facility Quality Assurance tracking log. Quality Assurance tracking logs will be reviewed during the monthly Quality Assurance meeting to monitor for compliance.</p>		

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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, record review and interviews, the facility failed to ensure there were medical indications to justify the use of a psychotropic medication and failed to timely monitor the medication use for 1 of 10 residents reviewed for unnecessary medications. (Resident #8)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #8 was reviewed on 06/18/13 at 9:00</p>	F000329	It is the policy of Miller's Merry Manor, Wakarusa, that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug that is used in an excessive dose, used without adequate indication for use, or is used in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of reasons. The medication regimen for Resident 8 has been reviewed by the physician to ensure that the resident is free	07/19/2013	

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	<p>A.M. Resident #8 was admitted on 01/14/2009, with diagnoses, including but not limited to, history of intestinal obstruction, insomnia, hypertonicity of the bladder, hypothyroidism, hypertension, edema, paralytic ileus, depressive disorder, osteoarthritis, esophageal reflux, and bladder cancer.</p> <p>A psychiatric evaluation, completed on 11/07/12, indicated the resident was receiving the antianxiety medication, Ativan 0.5 mg (milligrams) three times a day, Sertraline 75 mg, an antidepressant medication, at bedtime, and another antidepressant medication, bupropion 75 mg twice a day.</p> <p>The evaluation indicated the resident was reported to be delusional and crying by the Social Service Director (SSD). The psychiatrist indicated the "distressing behaviors" appeared to be "psychiatric in nature" and he ordered the antipsychotic medication, Risperdal .25 mg a day to be added to Resident #8's medication regimen.</p> <p>On 12/07/12, the Risperdal .25 mg a day was discontinued and the antipsychotic, Ability 2 mg one tablet per day was added for the diagnosis of "dementia with behaviors and</p>		<p>from unnecessary medication. The health care plan team will review & update this resident's behavior management program by 7/19/13 to ensure the psychosocial needs of the resident are being met. The facility policy & procedure for gradual dose reduction will be followed. All residents who are prescribed psychoactive medications are at risk to be affected by this deficient practice. The nurse managers will complete an audit of all current residents to ensure proper indication & diagnosis for use of any prescribed psychoactive medications by 7/19/13. The pharmacy consultant will continue to make monthly visits to complete onsite drug regimen reviews & will submit recommendations for drug reductions to the Director of Nursing. The Director of Nursing, or designee, will be responsible to communicate pharmacy recommendations to the physician & ensure timely physician response or follow up. The facility policies for "Behavior Assessment/Management Program" & "Psychotropic Drug Use" will be reviewed with all nursing staff by 7/19/13. The facility will continue to have monthly behavior meetings to review residents who are prescribed psychopharmacological medications, behavior</p>				

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	<p>resistant depression."</p> <p>The December 07/2012 psychiatric evaluation indicated the Social Service Director and the "staff" still reported "episodic crying." The evaluation went on to say the resident was "still experiencing behavior disturbances that are distressful."</p> <p>Review of the nursing progress notes from October 15 - November 07, 2012 indicated there was no behavioral issues documented for Resident #8.</p> <p>Review of the assessment section of the electronic clinical record, for October and November 2012, indicated there was no new behavioral occurrence assessments documented for Resident #8.</p> <p>There was no behavior tracking/monitoring documentation available for the months of October and November 2012. The December 2012, behavior tracking form for Resident #8 indicated she had displayed "mood issues as exhibited by: disruptive noises, excessive nervousness, restlessness, wringing hands, excessive worrying, excessive crying, and tearfulness." The form indicated on 22 shifts the resident had</p>		<p>patterns/target behaviors, pertinent diagnosis for use, & ensure physicians are notified of any pharmacy recommendations for gradual dose reductions. Resident specific interventions will be reviewed for effectiveness & changes will be made as needed to the residents plan of care. The charge nurses will be instructed to document any new onset of behavioral symptoms or worsening symptoms in the electronic medical record & on the 24 hour report sheet. The 24 hour report sheet will serve as a communication tool & will be reviewed routinely by the nurse management team to ensure prompt intervention by the health care plan for the new onset of behavior/worsening behaviors. The nursing assignment sheets will be used to communicate resident specific behavior programs & the interventions in plan of care to prevent/reduce the frequency of target behaviors, etc. Any episodes of behavior will be documented in the electronic medical record along with the effectiveness of the health care plan interventions each shift & prn. The Social Services Director, or designee, will be responsible to complete the Quality Assurance tool titled "Behavior and Antipsychotic Medication Review" (Attachment A) on 10 residents weekly for 4 weeks, then 10 residents monthly thereafter, to monitor for ongoing compliance.</p>		

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	<p>displayed some kind of mood issue but the specific type of issue was not documented on the form. On 7 of the 22 documented shifts the mood issue improved when non-pharmalogical interventions were attempted. The interventions on the Behavior Management form for December 2012 indicated staff were to asses the resident for unmet needs, provide calm surroundings, reassurance and TLC (tender loving care), and provide personal space. The documentation was not specific as to which intervention had been successful or had been attempted. There was no specific plan to address delusions or hallucinations for Resident #8.</p> <p>Interview with the SSD on 06/18/13 at 1:07 P.M., indicated the resident was on Ability for hallucinations which caused her to cry. The SSD indicated the resident's behaviors increased "if you try to talk to her." The SSD indicated this occurred when you asked her why she was crying. The SSD indicated Resident #8 " does better if you try to change the subject. If you really listen to what she is saying as she's crying it is usually about a hallucination she is having." The SSD indicated she could not find the behavior tracking October and November 2012.</p>		<p>This system for monitoring will be reviewed during the monthly Quality Assurance meeting & any findings will be corrected logged on a Quality Assurance summary log to monitor for compliance.</p>				

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	<p>Interview with the SSD, on 06/19/13 at 10:00 A.M., indicated she did not put out the monitoring forms for Resident #8 until December 2012 when she realized an audit tool revealed the need for the forms.</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5)</p>				