

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
F0000	<p>This visit was for the Investigation of Complaint IN00105436.</p> <p>Complaint IN00105436 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F514.</p> <p>Survey date: April 2, 2012</p> <p>Facility number: 000020 Provider number: 155059 AIM number: 100288690</p> <p>Survey team: Jeri Curtis, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 58 Total: 62</p> <p>Census payor type: Medicare: 12 Medicaid: 42 Other: 8 Total: 62</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p>	F0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Quality review completed 4/5/12 by Jennie Bartelt, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 provide assessment and management of the increased edema for 1 (Resident A) of 3 residents reviewed for change of condition in a sample of 3.</p> <p>Findings include:</p> <p>The closed record of Resident (A) was reviewed 4/2/2012, and indicated an April 2009 admission with diagnoses including schizophrenia, hypertension, diabetes, and dysphagia.</p> <p>A 2/9/12, 9:43 P.M., nursing note indicated the physician was notified related to increased confusion and increased edema to the bilateral lower legs. The blood pressure (B/P) was 106/55, pulse 90, and temperature 98.2. Breath sounds were clear, and skin was warm and pink. Documentation indicated the physician ordered the antibiotic (possible urinary tract infection) to be continued twice daily.</p>	F0309	<p>F 309 It is the policy of Miller's Merry Manor, Huntington that each resident will be provided 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. Resident A has been discharged from the facility. All residents have the potential to be affected by this deficient practice. Any resident with notable change in condition will be assessed thoroughly by the licensed nurse. Findings are to be documented in the clinical record, family and physician notification will also be completed and documented in the record. Licensed staff will document change on the alert charting follow-up board. Resident will be assessed at least once per shift and required documentation completed. This will continue until the issue is resolved. Care plans will be updated accordingly with changes. To ensure the above measures are followed the facility will be providing training to</p>	04/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>The last nursing note documentation prior to the resident's discharge to the hospital on 2/13/12, was on 2/10/12 at 8:10 P.M., indicating a physician order to increase Lasix (a diuretic) to 60 mg (milligrams) every day. The order indicated the legs were to be elevated while sitting, and a CBC (complete blood count), BMP (basic metabolism panel) and lipid profile were ordered for the next week. Pharmacy and family were notified.</p> <p>A 2/13/12 physician's order indicated to send the resident to emergency room for evaluation and treatment.</p> <p>The nursing note documentation did not indicate assessment of breath sounds, vital signs, or presence, absence, or change in the leg edema from 2/10 through 2/13/12. Nursing note documentation did not indicate the change of condition on 2/13/12, notification to the family and physician, orders for a hospital evaluation, nor the condition on transfer.</p> <p>During a 10:20 A.M., 4/2/12 interview, the Administrator and Director of Nursing (DoN) indicated the family of Resident (A) had expressed concerns about the cause of the 2/13/12 death. The Administrator indicated the family's concerns related to pneumonia as a cause</p>		<p>licenses nurses regarding assessment and documentation .This will be completed by 4/23/12. Also the DON / Designee will be reviewing charting daily to ensure proper documentation and assessment is completed for any resident with change of condition. The DON / Designee will utilize the Q/A tool "24 Hour Condition report "Attachment (A) This tool will be completed daily for the next 30 days. Any identified issues will be addressed immediately. Results of audit and action taken will be documented on the form. After 30 days the DON/ Designee will complete the audit tool monthly on at least 10% of the resident population. This will be ongoing indefinitely. Concerns and trends will be indicated on the Q/A Summary log. Attachment (B) All Q/A Tools /audits will be reviewed by interdisciplinary team in the monthly Q/A meeting Date of compliance 4/26/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>of death (included on death certificate). The Administrator indicated Resident (A) had been transferred to the local hospital on 2/13/12, then on to a regional hospital, and had expired in a hospice unit. The Administrator indicated Family Member #1 had requested an independent review of the record, and a corporate nurse, whose duties included quality assurance, had performed a review. The DoN indicated Family Member #1 was concerned the facility had not advised the family of the pneumonia. The DoN indicated the corporate quality review had indicated no concerns with the 2/11-2/12/12, week-end monitoring of the antibiotic therapy for a urinary tract infection (UTI). The DoN indicated lab results of the urinalysis, received later, indicated no bacteria, no infection. The DoN indicated Resident (A) was sent out for an evaluation on Monday, 2/13/12, with respiratory distress.</p> <p>The facility Medical Director was interviewed at 12:25 P.M., 4/2/12, and indicated Resident (A) had cold symptoms two days prior and a possible UTI (urinary tract infection). The Medical Director indicated he had ordered antibiotic therapy. The Medical Director indicated Resident (A) also had confusion with increased edema in the legs, then developed acute respiratory</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>distress on 2/13/12. The Medical Director indicated the blood gas drawn in the local emergency room (ER) showed a low pH level consistent with acidosis. The Medical Director indicated Resident (A) had scoliosis and a high risk for aspiration, which was a possibility with the diagnoses of pneumonia and respiratory failure. The Medical Director indicated the family was initially unsure about aggressive measures, but requested intubation. The Medical Director indicated his review of the labs and x-rays done at the regional hospital indicated significant alveolar infiltrates with probable pneumonia, and septic shock, or cardiogenic shock.</p> <p>At 1:00 P.M., 4/2/12, the Director of Nursing (DoN), provided additional copies of the record which she indicated the family had requested following the death of Resident (A). The copies included a 2/13/12, 10:00 A.M., hospital transfer record. A computerized column of the transfer record titled, Reason for Transfer/Include Full Assessment and Vital Signs, indicated a B/P of 112/67, pulse-103, respirations -33, 02 - 77 (oxygen saturation level) on room air, 94 on 2.5 liters of oxygen, left hand swollen, and very confused at this time.</p> <p>The DoN also provided copies of nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>infection assessments for the UTI from 2/10-2/13/12. Each of the assessments included the body system affected, genitourinary, with a check mark indicating follow-up of oral antibiotic treatment, and a temperature. The 2/13/12, 2:18 A.M., antibiotic monitoring form indicated a temperature of 98.8. Documentation did not indicate further assessment.</p> <p>At 2:15 P.M., 4/2/12, a visit was made to the local hospital and copies of the 2/13/12 hospital ER evaluation were obtained. The ER report indicated Resident (A) had arrived by ambulance after becoming unresponsive at the nursing facility. Documentation indicated apparent increased difficulty with breathing and signs of congestive heart failure over the past several days with an increase in the Lasix. Lasix was given IV and an aerosol treatment for rhonchi in the lower lobes. Resident (A) was unresponsive. An x-ray revealed significant congestive heart failure. Resident (A) was placed on BiPap (forced air oxygenation). Resident (A) was admitted to the medical intensive care unit, and underwent additional tests and consults while awaiting a decision from the family regarding a transfer to the regional hospital.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>Family Member #1 was interviewed by telephone at 3:10 P.M., 4/2/12, and indicated respiratory failure, congestive heart failure and pneumonia were listed as causes on the death certificate. Family Member #1 indicated a concern the lungs were not checked the week-end of 2/11-2/12/12, after an increase in the edema. Family Member #1 indicated a concern the symptoms of pneumonia were not identified by the facility due to lack of assessment.</p> <p>The DoN was interviewed at 3:00 P.M., 4/2/12, and indicated lung sound assessments had not been completed the week-end of 2/11-2/12/12. The DoN indicated the 24 hour sheets had not indicated a change in the condition the week-end of 2/11/12-2/12/12. The DoN indicated facility documentation protocols were no late entries to be made after a transfer from the facility. The DoN indicated she had inserviced staff on accurate, complete, documentation following the 2/13/12 incident.</p> <p>During this interview, the DoN indicated the Licensed Practical Nurse (LPN #1) who had sent Resident (A) to the hospital the morning of 2/13/12, was no longer employed and was unavailable for interview.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
	<p>LPN #2, who had also been on duty the morning of 2/13/12, was interviewed at 3:20 P.M., 4/2/12. LPN #2 indicated LPN #1 had asked her to check Resident (A) due to confusion and a decreased oxygen saturation level. LPN #2 indicated when she saw Resident (A), the oxygen had been placed. LPN #2 indicated Resident (A) had not been oxygen dependent prior. LPN #2 indicated she had observed swelling in the left hand and 2 plus leg edema. LPN #2 indicated Resident (A) was pale and clammy. LPN #2 indicated LPN #1 had checked the vital signs and lung sounds, called the MD, then sent Resident (A) to the hospital for an evaluation as ordered.</p> <p>Certified Nursing Assistant (CNA #1) was interviewed at 4:00 P.M., 4/2/12, and indicated she had provided care to Resident (A) on 2/11/12. CNA #1 indicated Resident (A) had gotten up, brushed the teeth, took breakfast and lunch, and was talking with her. CNA #1 indicated she next saw Resident (A) the morning of 2/13/12. CNA #1 indicated she had gotten the roommate of Resident (A) up for breakfast and (Resident A) had seemed okay. CNA #1 indicated she recalled Resident (A) had eaten breakfast. CNA #1 indicated between 8:30-9:30 A.M., 2/13/12, she put the roommate to bed and noticed Resident (A) was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>clammy, not her usual self, and the left hand was puffy. CNA#1 indicated she had alerted LPN #1. CNA #1 indicated she was in the room when the EMS (emergency medical service) arrived. CNA #1 indicated the EMS placed an oxygen mask and Resident (A) had tried to push it away. CNA#1 indicated the next day she was told Resident (A) had passed away at the hospital.</p> <p>At 4:10 P.M., 4/2/12, the DoN provided a copy of the 24 hour reports from 2/11-2/13/12. Review of the reports related to Resident (A) indicated on the 2/11/12 night shift report, a blood sugar of 127, and, "Lasix." The 2/12/12, day shift report indicated intake improving. The 2/12/12 night shift report indicated a blood sugar of 204, a blood pressure of 127/61, and a pulse of 108. The 2/13/12 day shift report indicated respirations at 33, labored, 02-(oxygen saturation level) 77 on room air, 94 on N/C (nasal cannula oxygen), left hand edema 2 plus, breath sounds clear. The 2/13/12, 8:58 P.M., report indicated, "passed." The DoN indicated the 24 hour sheets did not provide too much additional information, however showed an assessment prior to the hospital transfer.</p> <p>The DoN indicated if there had been no change during the week-end of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>2/11-2/12/12, she would not necessarily expect documentation in the nursing notes.</p> <p>The DoN also provided the 2/13/12 food/fluid intakes for Resident (A). The intake record indicated 480 ccs (cubic centimeters) of fluid for breakfast. The DoN indicated she had reviewed the record of Resident (A) at the time and had been concerned there was no documentation for the change of condition the morning of 2/13/12, to show assessment and the intervention of oxygen The DoN indicated she had spoken to LPN #1 at the time regarding assessment and documentation.</p> <p>The 3/1/12 Notification of Condition Changes to Physician and Family Policy was provided by the Administrator on 4/2/12. Under Section C, Procedure, the policy indicated the nurse was to document the information reported to the physician in the nursing notes, including the time and date of notification. Documentation was to be thorough and explicit. The policy also indicated the response from the physician was to be documented in the nursing notes.</p> <p>This federal tag relates to Complaint IN00105436.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750		
(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	
	3.1-37(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750			
(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			
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to assure accurate, complete documentation of a change in condition for 1 (Resident A) of 3 residents reviewed for change of condition with accurate, complete documentation.</p> <p>Findings include:</p> <p>The closed record of Resident (A) was reviewed 4/2/2012, and indicated a 4/09, admission with diagnoses including schizophrenia, hypertension, diabetes, and dysphagia.</p> <p>A 2/9/12, 9:43 P.M., nursing note indicated the physician was notified related to increased confusion and increased edema to the bilateral lower legs. Blood pressure was (B/P) 106/55, pulse 90, and temperature 98.2. Breath</p>	F0514	<p>F514 It is the policy of Miller's Merry Manor Huntington to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible and systemically organized. Resident A has been discharged from the facility. All residents have the potential to be affected by this deficient practice.</p> <p>Any resident with notable change in condition will be assessed thoroughly by the licensed nurse. Findings are to be documented in the clinical record, family and physician notification will also be completed and documented in the record. Licensed staff will document change on the alert charting follow-up board. Resident will be assessed at least once per shift and required documentation completed. This will continue until</p>	04/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750		
(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	
	<p>sounds were clear, and the skin warm and pink. Orders were received to continue the antibiotic (possible urinary tract infection), twice daily.</p> <p>The next and last nursing note documentation prior to the resident's discharge to the hospital on 2/13/12, was on 2/10/12 at 8:10 P.M., indicating a physician order for the Lantus Insulin to be discontinued and Levemir 20 units daily to be started. Orders indicated it was OK to change insulin coverage from Novolin R to Novolog. The Lasix (a diuretic) was increased to 60 mg (milligrams) every day. The legs were to be kept elevated while sitting. A CBC (complete blood count), BMP (basic metabolism panel) and lipid profile were to be done next week. Pharmacy and family notified.</p> <p>A 2/13/12 physician's order indicated to send the resident to the emergency room for evaluation and treatment.</p> <p>The nursing note documentation from 2/10 - 2/13/12, did not indicate assessment of breath sounds, vital signs, or presence, absence, or change in the leg edema. Nursing note documentation did not indicate the change of condition on 2/13/12, notification to the family and physician, orders for a hospital</p>		<p>the issue is resolved. Care plans will be updated accordingly with changes. To ensure the above measures are followed the facility will be providing training to licenses nurses regarding assessment and documentation .This will be completed by 4/23/12. Also the DON / Designee will be reviewing charting daily to ensure proper documentation and assessment is completed for any resident with change of condition. The DON / Designee will utilize the Q/A tool "24 Hour Condition report Attachment (A) This tool will be completed daily for the next 30 days. Any identified issues will be addressed immediately. Results of audit and action taken will be documented on the form. After 30 days the DON/ Designee will complete the audit tool monthly on at least 10% of the resident population. This will be ongoing indefinitely. Concerns and trends will be indicated on the Q/A Summary log. Attachment (B) All Q/A Tools /audits will be reviewed by interdisciplinary team in the monthly Q/A meeting. Date of compliance 4/26/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>evaluation, nor the condition on transfer.</p> <p>At 1:00 P.M., 4/2/12, the Director of Nursing (DoN), provided additional copies of the record, which she indicated the family had requested following the death of Resident (A). The copies included a 2/13/12, 10:00 A.M., hospital transfer record. A computerized column of the transfer record titled, Reason for transfer/including full assessment and vital signs, indicated a B/P of 112/67, pulse-103, respirations-33, O2-77 (oxygen saturation level) on room air, 94 on 2.5 liters of oxygen, left hand swollen, and very confused at this time.</p> <p>The DoN also provided copies of nursing infection assessments from 2/10-2/13/12. Each of the assessments included the body system affected, genitourinary, with a check mark indicating follow-up of oral antibiotic treatment, and a temperature. The 2/13/12, 2:18 A.M., antibiotic monitoring form indicated a temperature of 98.8.</p> <p>The DoN was interviewed at 3:00 P.M., 4/2/12, and indicated facility documentation protocols were for no late entries were to be made after a transfer from the facility. The DoN indicated documentation was to be accurate and complete. The DoN indicated she had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 GRANT ST HUNTINGTON, IN 46750
--	--

(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
	<p>inserviced staff on the importance of accurate, complete documentation following the 2/13/12 incident.</p> <p>The 3/1/12 Notification of Condition Changes to Physician and Family Policy was provided by the Administrator on 4/2/12. Under Section C, Procedure, the policy indicated the nurse was to document the information reported to the physician in the nursing notes, including the time and date of notification. Documentation was to be thorough and explicit. The policy also indicated the response from the physician was to be documented in the nursing notes.</p> <p>This federal tag relates to Complaint IN00105436.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			