

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 10/23/2014
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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 a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00157731 completed October 23, 2014.</p> <p>Complaint IN00157731-Substantiated. Federal/State deficiencies related to the allegations are cited at F-315, F-323, F-328 and F-333.</p> <p>Survey Dates: October 15, 16, 17, 20, 21, 22, and 23, 2014.</p> <p>Facility number: 000505 Provider number: 155556 AIM number: 100266350</p> <p>Survey team: Sandra Nolder, RN, TC Michelle Hosteter, RN Gloria Bond, RN October 15, 16, and 17, 2014 Tammy Alley, RN October 20, 21, and 23, 2014</p> <p>Census bed type: SNF:18 SNF/NF: 98 Total: 116</p>	F000000	<p>Mrs. Tammy Alley, Please accept the following plans of correction as credible allegation of compliance to the deficiencies cited during the survey conducted here on Oct. 15th, 2014. If you have any questions or need any further information, please do not hesitate to contact me here at the facility at 765-675-8791. The facility also respectfully requests that paper compliance be considered. Sincerely, Troy Clements</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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F000156 SS=A	<p>Census payor type: Medicare: 13 Medicaid: 74 Other: 29 Total: 116</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on October 29, 2014.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the</p>				

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	<p>State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman</p>			

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	<p>program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to inform residents their skilled nursing services had ended in a timely manner for 3 or 4 residents reviewed for Notice of Medicare Non-Coverage. (Residents #4, #11 and #58)</p> <p>Findings include:</p> <p>The following residents were given Notice of Medicare Non-Coverage notices that indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: [date]... Please sign below to indicate you received and understood this notice. I</p>	F000156	F156 It is the policy of Miller's Merry Manor to complete all required CMS Notices in accordance with the CMS regulations and provide the beneficiary and/or legal representative a copy of each notice and their rights for filing an appeal. All resident's have the potential to be affected by this deficient practice. To prevent recurrence of this deficient practice all staff who are responsible for providing Notices of Medicare Non-Coverage will be in-serviced on the policy entitled "Policy and Procedure For CMS Notices Medicare Letters of Non-Coverage Expedited Determination; GN & DN" (attachment 1M 1-4). The Office	11/22/2014

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	<p>have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]."</p> <p>On 10/23/14 at 9:39 a.m., Resident #4's record was reviewed. She was discharged from Skilled Nursing Services on 9/11/14. Her Notice of Medicare Non-Coverage letter indicated her effective date of services ended on 9/11/14. The letter indicated the resident's responsible party had not signed the Notice of Medicare Non-Coverage as of 10/15/14.</p> <p>On 10/23/14 at 10:34 a.m., Resident #11's record was reviewed. She was discharged from Comprehensive Rehabilitation Services on 8/26/14. Her Notice of Medicare Non-Coverage letter indicated her effective date of services ended on 8/26/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 8/27/14.</p> <p>On 10/23/14 at 9:41 p.m., Resident #58's record was reviewed. She was discharged from Comprehensive Rehabilitation Services on 7/12/14. Her Notice of Medicare Non-Coverage letter</p>		<p>Manager will complete the QA Tool (2M 1-2) daily for 2 weeks, weekly for 4 weeks then monthly there after for ongoing compliance. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting along with any new recommendations implemented. Corrective actions will be completed by 11/22/14.</p>		

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	<p>indicated her effective date of services ended on 7/12/14. The letter indicated the resident signed the Notice of Medicare Non-Coverage letter on 7/15/14.</p> <p>During an interview on 10/22/14 at 5:37 p.m., RN # 1 indicated Comprehensive Rehabilitation was Physical, Occupational and Speech Therapies. She indicated the service end date was the last date of covered services. She indicated she was responsible for the Medicare A residents and the Social Service Director (SSD) was responsible for the Medicare B residents. She indicated she had 48 hours before their service end date to give the Notice of Medicare Non-Coverage Letter to the residents. She indicated Resident # 4's service end date was on 9/11/14, and her son was sent a copy of the notice for his signature, but he never sent it back and she did not send a second notice. She indicated she failed to document that date and time that she had sent the first Notice of Medicare Non-Coveage out to the resident's son.</p> <p>RN # 1 indicated 8/27/14 was the day Resident # 11 was discharged out of the facility. She indicated on 8/20/14, she gave the resident a verbal notification of her service end date. The resident needed to call for an appeal by 8/25/14, but RN #</p>			

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F000241 SS=D	<p>I had not given her a written copy of the notice. She indicated she had the resident sign the written copy of the Non-Coverage notice the day she discharged. RN # 1 indicated when she was trained by the previous Case Manager, she understood that a verbal notice could be given, then she would to have the written notice signed on the day of discharge. She indicated Resident # 58's service end date was 7/12/14, but she did not give the Notice of Medicare non-Coverage until 7/15/14, because the resident wanted to stay a few extra days as private pay.</p> <p>3.1-4(f)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and had gait belts removed after being transferred for 2 of 2 residents (Resident O and #117) and failed to use a gait belt during 1 of 3 transfers for residents observed for transfers. (Resident O)</p> <p>Findings include:</p>	F000241	<p>F 241 Dignity and respect of individuality:</p> <p>It is the policy of Miller's Merry Manor to enhance and promote resident dignity at all times. All resident's have the potential to be affected by this deficient practice. To prevent recurrence of this deficient practice all staff will be</p>	11/22/2014

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	<p>1. a. On the following date and times, Resident O was observed wearing a gait belt:</p> <p>On 10/20/14 at 10:11 a.m., the resident was observed laying in his bed snoring with a gait belt around his breast area.</p> <p>On 10/20/14 at 11:41 a.m., the resident was observed laying in his bed awake with a gait belt around his breast area.</p> <p>b. On the following date and times, Resident # 117 was observed wearing a gait belt:</p> <p>On 10/16/14 at 1:30 p.m., the resident was observed sitting in her recliner in her room with a gait belt on around her breast area. She indicated at that time that gait belts got left on her at times.</p> <p>On 10/16/14 at 3:30 p.m., the resident was observed sitting in her recliner in her room with a gait belt on around her breast area.</p> <p>During an interview on 10/21/14 at 4:50 p.m., CNA # 5 indicated that she placed the gait belt around the resident's waist during transfers and removed it after the transfer. She indicated she did not place it around the breast area due to it was not</p>		<p>in-serviced on Policy titled "Resident Dignity" (1a) and Nursing staff will be in-service on policy titled "Gait Belt Use Procedure" (1b) on 11/7/14. The DON or designee will complete the Resident Dignity/Gait Belt Use QA Tool (1c) daily for 2 weeks, weekly for 4 weeks then monthly there after for ongoing compliance. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting along with any new recommendations implemented. Corrective actions will be completed by 11/22/14.</p>				

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	<p>suppose to go around the breast area.</p> <p>During an interview on 10/21/14 at 5:06 p.m., CNA # 6 indicated she placed the gait belt around the waist and took it off and put it away when she was finished with the transfer of the resident.</p> <p>2. On 10/22/14 at 1:51 p.m., Resident O's record was reviewed. Diagnoses included, but were not limited to, generalized muscle weakness, lack of coordination, difficulty in walking and abnormality of gait.</p> <p>On 10/21/14 at 4:45 p.m., CNA # 5 and CNA # 6 were observed transferring the resident from the bed to his wheelchair. CNA # 5 was observed sitting the resident on the side of the bed and CNA # 6 placed the gait belt loosely around his waist. CNA # 5 lifted the resident under his left arm, and had her hand holding onto the gait belt, while CNA # 6 had her hand under his right arm and had her hand holding onto his pants with the gait belt laid over the top of her hand, while the two CNA's transferred him into his wheelchair. While CNA # 6 was lifting the resident off the bed by the back of the waist band of his pants to lift him to transfer him, his right pant leg, by his ankle was raised allowing his sock on his right ankle to be seen.</p>			

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	<p>During an interview on 10/21/14 at 5:06 p.m., CNA # 6 indicated the gait belt she placed on the resident should have been tightened when she placed it on him. She indicated she grabbed the resident by the back of his pants to lift him off the bed and transfer him into his wheelchair instead of using the gait belt.</p> <p>A current policy titled "Gait Belt Use Procedure" dated 07/27/2012, provided by the Administrator on 10/21/14 at 5:07 p.m., indicated "1. PURPOSE: To insure safety in transfer and ambulation... 2. PROCEDURE: A. Transfer:... III. Place belt around resident's waist with the buckle in front (on top of resident's clothes) and adjust to a secure, snug fit ensuring that you can get your hands under the belt. IV. After properly positioning resident for the transfer, grasp belt on each side of resident's waist and assist the resident to stand on count of three...Vii. After transfer complete, return resident to chair or bed, unfasten belt and slowly remove from resident's waist..."</p> <p>A current policy titled "Transfer from Bed to Chair" dated 03/01/2001, provided by the Assistant Director of Nursing on 10/22/14 at 4:45 p.m., indicated "9. Transfer from Bed to Chair:</p>			
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F000312 SS=D	<p>A. PURPOSE: 1. To allow the resident to be out of his or her bed as much as possible and to encourage the resident to participate in activity and social activities. B. PROCEDURE:... 7. Assist the resident to a sitting position on the side of the bed. 8. Apply gait belt to waist if resident requires weight bearing assist. (see gait belt procedure) 9. Using gait belt-grasp sides of belt with both hands and assist resident to standing position: pivot turn and sit resident in chair...."</p> <p>3.1-3(t)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to follow dressing assistance for 1 of 5 residents observed for Activities of Daily Living (ADL's). (Resident C)</p> <p>Findings include: On 10/21/14 at 4:30 p.m., Resident C's record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, colostomy, and</p>	F000312	<p>F 312 ADL care provided for dependent residents:</p> <p>It is the policy of Miller's Merry Manor for all residents unable to carry out activities of daily living to receive necessary services to maintain good nutrition, grooming and personal/oral hygiene. All resident's have the potential to be affected by this deficient practice. To prevent recurrence of this deficient practice nursing staff will</p>	11/22/2014

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	<p>aftercare for healing traumatic fracture of hip.</p> <p>The resident had a Care Plan dated 4/4/11, and revised on 1/8/13, that addressed the problem she needed total assist with her ADL's due to she had dementia and had weakness.</p> <p>Interventions/Tasks included, but were not limited to, "4/4/11-Encourage to participate in ADL's as much as possible...ADL-Needs cueing/reminders and assistance for bathing/dressing/grooming...Assist with all transfers."</p> <p>The resident had a Care Plan dated 6/5/13, that addressed the problem she required set up and verbal cueing to participate in daily dressing due to she had decreased mobility.</p> <p>Interventions/Tasks included, but were not limited to, "6/5/13--Restorative Program: Set up supplies: offer verbal directions as needed. Give praise as resident completes the task. Place wash cloth in hand as needed. Restorative program. Set up supplies, offer verbal directions as needed. Give praise as resident completes the task. Place wash cloth in hand as needed. Ensure clothing is within reach. Assist to finish task as</p>		<p>be in-serviced on Policy titled "Bed time Care Policy" (2a) and "Morning Care Policy" (2b) on 11/7/14. The DON or designee will complete the Resident ADL Dignity QA Tool (2c) daily for 2 weeks, weekly for 4 weeks then monthly there after for ongoing compliance. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting along with any new recommendations implemented. Corrective actions will be completed by 11/22/14.</p>				

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	<p>needed."</p> <p>The resident's Quarterly MDS (Minimum Data Set) assessment dated 8/5/14, indicated: Her functional status indicated her dressing was limited assist with one person physical assist.</p> <p>The resident was in a sweatshirt with 2 bears and a brown pair of pants on the following dates and times: 10/20/14 at 11:35 a.m. 10/20/14 at 2:15 p.m. 10/20/14 at 4:20 p.m. 10/21/14 at 10:00 a.m., There was a faint body odor noted while standing next to the resident. 10/21/14 at 11:50 a.m. 10/21/14 at 2:00 p.m. 10/21/14 at 2:17 p.m.</p> <p>During an interview on 10/21/14 at 2:40 p.m., CNA # 7 indicated the resident refused at times at night to change her clothes into her pajamas. He indicated a CNA should report when residents refused to change their clothes, so the nurse could document the refusal on the clipboard.</p> <p>During an interview on 10/21/14 at 2:44 p.m., LPN # 8 indicated the CNA's reported to her when residents refused to</p>				

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	<p>change their clothes and she would document the refusal in the progress notes. She indicated the dayshift CNA that worked today on 10/21/14, did not report to her that this resident had refused to change her clothes today. She indicated that the resident rarely refused to change her clothes and if the CNA waited, then went back in the room she would usually let them change her clothes. She indicated she did not know the resident had the same outfit on for 2 days.</p> <p>During an interview on 10/21/14 on 2:47 p.m., LPN # 9 indicated the CNA that worked last night did not report to her that the resident had refused to change her clothes. She indicated that if the resident had refused to change clothes, the CNA's reported the refusal to the nurse. The nurse documented in the progress notes the resident refused to change her clothes She indicated she did not realize the resident had the same outfit for 2 days in a row.</p> <p>During an interview on 10/21/14 at 2:56 p.m., LPN # 10 indicated the CNA's attempted to change the resident's clothes and if unable then they notified the nurse. The nurse then attempted to change the resident's clothes and if unable the nurse notified the Unit Manager, so the refusal</p>			

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	<p>of care could be care planned and the nurse documented the refusals of any care in the progress notes.</p> <p>During an interview on 10/21/14 at 4:20 p.m., LPN # 10 indicated the resident's clothes was changed after it was brought to the facilities attention she had not had her clothes changed for 2 days. She indicated there was no problem changing her clothes.</p> <p>During an interview on 10/21/14 at 6:15 p.m., the Administrator indicated he had investigated whether the residents clothes were changed last night on 10/20/14. He indicated he spoke with the CNA # 7 who cared for her last night and he had not gotten her ready for bed last night. CNA # 7 indicated she must have transferred herself to bed and he had not checked to verify whether she had her clothes on or not before he left his shift. The Administrator indicated CNA # 11 had noticed during the night while providing care to this resident's roommate that this resident had her clothes on and she tried to get the resident to change her clothes, but she refused.</p> <p>The Administrator indicated he spoke to LPN # 13 and she was not informed the resident had her clothes on all night</p>						

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F000315 SS=D	<p>because she refused to change them. The Administrator indicated he spoke to the CNA that cared for the resident on 10/20/14, on dayshift and she saw the resident had clothes on when she went into her room to get her up for breakfast, so she "assumed" CNA # 11 had gotten her dressed before she left that morning, so she did not change her clothes. The Administrator indicated there was to be a walking shift to shift report between each shift and the midnight shift CNA should have reported to the dayshift CNA that the resident had worn her clothes to bed and refused to let CNA # 11 change her clothes, so the dayshift CNA could have changed her clothes.</p> <p>3.1-38(b)(4)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review, observation and interview, the facility failed to ensure</p>	F000315	F 315 No catheter, prevent UTI,	11/22/2014	

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	<p>anchored catheter drainage bag and tubing were positioned in a manner to prevent the possibility of infection for 1 of 4 residents reviewed for urinary tract infections in a sample of 4. (Resident P)</p> <p>Findings include:</p> <p>During an interview with the Assistant Director of Nursing on 10/16/14 at 12:11 p.m., she indicated she would look for the diagnoses for the use of the catheter. She indicated she thought it was for debilitation and pain.</p> <p>During an observation on 10/20/14 at 10:14 a.m., Resident P was in bed, the anchored catheter drainage bag was hanging on the side of the bed. At 10:16 a.m., during an observation of a Hoyer lift transfer with CNA # 2 and # 3, neither were wearing gloves, CNA # 2 placed the anchored catheter drainage bag onto the hook of the Hoyer lift with the drainage bag above the level of the bladder. There was yellow urine in the tubing. After the resident was positioned in her wheelchair, the anchored catheter drainage bag and tubing were positioned into the dignity bag at the rear base of the wheelchair. As this occurred, the tubing was on the floor. The dignity bag broke and the tubing remained on the floor as a new dignity bag was retrieved from the</p>		<p>restore bladder:</p> <p>Please accept the following credible allegation of compliance to the deficient practice cited under tag F315, of which ALL residents had the potential to be affected by. It is the Policy of Miller's Merry Manor-Tipton that all residents receive the appropriate treatment and services to prevent UTI. This includes tubing not touching the ground and the catheter bag to never come above bladder level. To correct the deficient practice all nursing staff will be in-serviced on 11/7/14. The in-service will include overview of the Policy titled "Foley Catheter Care and Maintenance" (3a1-2). For continued compliance the "Urinary Catheter" QA Tool (3b) 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 11/22/14.</p>				

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	<p>nurse. At 10:23 a.m., RN # 4 arrived with a new dignity bag and placed it on the rear base of the wheelchair. During this process the catheter tubing remained on the floor. CNA # 3 then positioned the residents wheelchair by her bedside, and the tubing remained on the floor under the wheelchair. During an interview at that time, CNA # 2 indicated she was unsure where to place the anchored catheter drainage bag so it would be below the bladder while using the Hoyer lift. She also indicated the tubing for the anchored catheter was on the floor under the wheelchair. She indicated the clip to hold tubing off the floor was missing.</p> <p>The record for Resident # 16 was reviewed on 10/20/14 at 10:43 a.m. Current diagnoses included, but were not limited to, obesity, history of Methacillin Resistant Staphylococcus Auresus (MRSA), and chronic pain.</p> <p>A Physician's order dated 9/17/14, indicated "...Cath: Ensure catheter bag is below waist, covered and tubing is not touching floor... "</p> <p>A Physician order dated 10/16/14, indicated to add the diagnoses of chronic pain for the Foley catheter use.</p>			

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	<p>A plan of care dated 1/16/14, and updated on 10/16/14, indicated the resident had a catheter for the use of debilitation and pain. Approaches to the plan of care included, but were not limited to, maintain the urinary drainage bag below bladder level to facilitate flow of urine.</p> <p>A plan of care dated 4/16/14, indicated the resident had a Urinary Tract Infection and was treated with Doxycycline (antibiotic) 100 milligrams twice daily for 7 days.</p> <p>A progress noted dated 4/17/14, indicated the resident had a urinary tract infection and was treated with an antibiotic.</p> <p>During an observation with the DON (Director of Nursing) on 10/21/2014 at 11:23 a.m., the resident was up in her wheelchair in her room. The anchored catheter tubing was on the floor under the wheelchair and there was yellow urine in the tubing. At that time during the interview, the DON indicated the tubing should not be on the floor.</p> <p>A policy titled "Foley Catheter Care and Maintenance" was provided by the DON on 10/21/14 at 11 a.m., and deemed as current. The policy indicated: "...Purpose 1. To reduce the likelihood of infection....Catheter Care</p>			

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F000323 SS=D	<p>Procedure...apply gloves...Placement of Catheter Tubing Procedure 1. When in bed or wheel chair:...Ensure bag or tubing is not touching floor...."</p> <p>This Federal tag relates to complaint IN00157731.</p> <p>3.1-41(a)(2)</p> <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 interview, and record review, the facility failed to assess a resident for the appropriate transfer method for 1 of 1 resident reviewed for appropriate transfer methods. (Resident E)</p> <p>Findings include:</p> <p>On 10/23/14 at 10:50 p.m., Resident E's record was reviewed. Diagnoses included, but were not limited to, diabetes type II, Clostridium Difficile, end-stage dementia, unspecified peripheral vascular disease, and end-stage congestive heart failure.</p> <p>The resident had a Care Plan dated 10/22/14, that addressed the problem</p>	F000323	<p>F 323 Free of accident hazards/supervision/devices: It is the policy of Miller's Merry Manor to 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. All residents in the facility have the potential to be affected by deficient practice. All new residents transfer needs will be assessed/determined on our pre-admission screening forms and communicated to direct care staff and also placed on care plan (Attachment 4a 1-8). The transfer needs of all residents will be based on individual needs and will refer to in-house therapy for any declines for further</p>	11/22/2014			

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	<p>needs extensive to total assist with ADLS due to weakness.</p> <p>Interventions/Tasks included, but were not limited to, "...9/9/14-Assist as directed with transfers."</p> <p>A "Facility-Post Occurrence IDT (Interdisciplinary Team) & Fall Risk Assessment (Don/Designee only)" dated 10/10/14 at 1:09 p.m., indicated a CNA on the nightshift during a bed check on 10/10/14 at 3:30 a.m., found a 30.0 x 15.0 centimeter dark blue colored bruise to the resident's left side of his chest and back. The root cause of the bruise was determined to be from the stand up lift strap. The recommendations from the IDT indicated the staff was to stop using the stand up lift and was to begin using a mechanical lift for all transfers.</p> <p>During an interview on 10/23/14 at 11:50 a.m., CNA # 15 indicated the resident had been an extensive assist with two person physical assist with the use of a gait belt for transfers. The resident would not always bear weight during the transfers. CNA # 15 indicated the resident's bilateral knees buckled, placing all of his weight onto his arms and the gait belt the CNA's were using to transfer him. He was tired by the evening shift and the facility decided to try a stand up</p>		<p>evaluations as appropriate. All nursing staff will be In-serviced on the admission process for specific resident transfers needs on 11/7/14. All nursing staff will be In-serviced on facility policy for: "Gait Belt Use Procedure" (Attachment 4b); "Mechanical Lift Transfers" (Attachment 4c) with skill checks completed on 11/7/14. The "Standing Lift Procedure" check off tool (Attachment 4d1-2) will be utilized for spot checks on proper transfer methods. The "Gait belt use" QA tool (attachment 4e) and "Mechanical lift Transfers" QA tool (attachment 4f) will be completed on 5 random residents on different shifts daily for 1 week, weekly times 4 weeks, monthly times 3 months, then quarterly thereafter. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting, along with any new recommendations implemented. Corrective actions will be completed by 11/22/14.</p>	

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	<p>lift since he could hold himself up with his arms even if he could not bear all his weight on his legs. CNA # 15 indicated the evening shift used the stand up lift one time and after that one time he was bruised around his side and back, then he was switched to the mechanical lift.</p> <p>During the an interview on 10/23/14 at 11:50 a.m., CNA # 16 indicated the resident buckled his knees placing all his weight onto his arms and the gait belt, making the two person assist with the gait belt transfer difficult.</p> <p>During an interview on 10/13/14 at 1:40 p.m., CNA # 18 indicated if a resident was unable to be transferred by extensive assist and two person physical assist, the CNA's were to report this information to the nurse. The nurse filled out a Physical Therapy screen referral form to evaluate if the resident needed a different way to be transferred, or needed physical therapy for strengthening.</p> <p>During an interview on 10/23/14 at 2:30 p.m., LPN # 14 indicated the resident's CNA assignment sheet indicated he was to be transferred by the stand up lift from the time he was admitted to the facility until he was switched to the mechanical lift transfer method on 10/10/14. She indicated CNA # 15 went to the Physical</p>			

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F000328 SS=D	<p>Therapy department and spoke to an unidentified therapist at an undetermined time about the resident being weak during transfers. He was told by an unidentified therapist the resident used a gait belt while on the parallel bars. CNA # 15 misunderstood the therapist and used the gait belt and two person assist to transfer the resident.</p> <p>A document titled "Owner's Operator and Maintenance Manual" "Patient Slings" undated, provided by the Administrator on 10/23/14 at 4:46 p.m., indicated "Section 6-Using Standing, Stand Assist, Transport and Transfer One-Piece Style Slings. Positioning the Sling Around the Patient...Individuals that use the Standing Sling MUST be able to support the majority of their own weight, otherwise injury can occur...."</p> <p>This Federal tag relates to complaint IN00157731.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;</p>						

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	<p>Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to provide colostomy care for 1 of 3 residents (Resident D) and failed to provide care for a PICC (Peripherally Intravenous Central Catheter) care for 1 of 1 resident (Resident #132) reviewed for special treatments.</p> <p>Findings include:</p> <p>On 10/20/14 at 11:30 a.m., the record review for Resident D was reviewed. Diagnoses included, but were not limited to, dementia, depression and colostomy.</p> <p>The care plan dated 7/13/10, Colostomy-risk for complications to ostomy site: Empty bag when 1/2 to 3/4 full or as ordered. Change appliance as ordered. Notify physician as needed, Observe for complication such as hypoactive bowel sounds, distended abdomen and change in ostomy condition.</p> <p>The Physician's Recapitulation, dated July 2014 indicated, "...Colostomy care every shift and as needed (7/3/10), Colostomy-change bag weekly on Saturday and as needed (7/3/10).</p>	F000328	<p>F 328 Treatment/care for special needs:</p> <p>It is the policy of Miller's Merry Manor to ensure all resident's receive proper treatment and care for special treatments as ordered. All resident's have the potential to be affected by this deficient practice. To prevent recurrence of this deficient practice all Nursing staff will be in-serviced on the following policies; "Physician order transcription process" (attachment 5a 1-2), "Flushing" (attachment 5b 1-3), and "Colostomy – changing and emptying" (attachment 5c 1-2) on 11/7/14. The DON or designee will complete the "Treatment & Medication" QA Tool (attachment 5d) daily for 2 weeks then weekly for 4 weeks then monthly there after for ongoing compliance. Any concerns will be corrected immediately, logged on the facility QA tracking log and reviewed in the monthly QA meeting along with any new recommendations implemented. Corrective actions will be completed by 11/22/14.</p>	11/22/2014			

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	<p>A fax transmitted on 7/21/14 indicated, "... 1) problem : redness around colostomy area and groin has increased redness. No improvement with current treatment. Westcort [anti-itch medication] creme and Nystatin [antifungal medication] powder treatment not working can we try a different treatment..." There was a physician's hand written reply which indicated, "...Lortisone [antifungal medication] cream twice daily Difflocan [antifungal medication] 100 mg daily x 7 days, A & D [skin moisturizer] ointment BID...7/22/14- A & D ointment twice daily due to redness and irritation around colostomy area...."</p> <p>The physician progress notes dated 8/13/14 indicated, "...Plan Continue A & D ointment, monitoring closely emptying the ostomy often to avoid over distention and leakage. We have asked nursing to let us know in the next 3-5 days how it is progressing...."</p> <p>The Treatment Administration Record (TAR) for CNA's to document care indicated the Colostomy care was not completed on the following dates: 7/15- evening shift 8/1- days and evenings 8/2- days and evenings 8/3- nights and evenings</p>						

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	<p>8/4- all shifts 8/6- nights and days 8/7- days and evenings 8/17- days 8/18- evenings 8/25- evenings 8/31- nights</p> <p>The TAR for nurses indicated Colostomy -change bag weekly on Saturday and as needed was changed June- 8 times during month July- 9 times during month August- 5 times during month</p> <p>The Bowel Movement Report from 7/2/14 through 10/21/14, had one box designated for each shift to document the output from the colostomy. The document had empty boxes on the following dates: 7/3-night shift 7/6-night shift 7/12- night shift 7/15- night shift 7/24- night shift 7/30- night shift 9/15- evening and night shift 9/22- night shift 9/24- night shift 9/29- night shift 10/11- night shift</p> <p>On 10/21/14 at 5:40 p.m., the Assistant</p>			

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	<p>Director of Nursing (ADON) indicated on the TAR sheets when the CNA's sign the sheet it designated by their signature that it was done every shift and as needed. She indicated they sign it when they have completed Colostomy care, when CNA's burp (let extra air out) the bag, empty it, etc. She indicated the aides may empty it more than once a shift, when they do it would be documented on the TAR or the BM record. She also indicated they should notify the nurse if there was leaking or any other issues. A request was made for any information pertaining to follow up of the excoriation since 7/22/14; have they investigated a cause, such as; an allergy to adhesive, or leaking or any other issues that could be causing the resident to have problems with her colostomy.</p> <p>10/22/14 at 11:45 a.m., RN #4 indicated the resident's colostomy was somewhat red, but sometimes it had cleared up. She indicated they had used an adhesive powder to keep the Colostomy in place, but the resident screamed when it was put on. RN # 4 was unsure what else had been tried.</p> <p>On 10/22/14 at 3:30 p.m., the ADON was requested to provide any information pertaining to frequency of care, what</p>			

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 10/23/2014
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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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	<p>other methods they have tried to assist in providing treatment for the excoriation that had been in place since 7/22/14.</p> <p>On 10/22/14 at 5:15 p.m., the Assistant Director of Nursing indicated they had no more information to provide regarding the care of Resident D's colostomy.</p> <p>2. On 10/21/14 at 4:59 p.m., LPN #12 was observed giving a medication of 10 milliliters Normal saline and pushing it into the PICC (Peripherally Intravenous Central Catheter) line of Resident #132, after the resident's IV antibiotic completed.</p> <p>On 10/21/14 at 5:02 p.m., LPN #12 indicated that Heparin (a medication to thin blood) was no longer used in PICC lines, they just used saline.</p> <p>On 10/23/14 at 11:30 a.m., the Director of Nursing indicated the nurse RN # 4 had asked if they were to use heparain on Resident #132 and her PICC line. The DON indicated that there was not an order for that, that it was just an FYI (For Your Information).</p> <p>On 10/23/14 at 11:35 a.m., RN #4 indicated she had always used heparain, and when she read the Medication Administration Record (MAR) which</p>			

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	<p>indicated, "...10/21/14 0000- FYI- IV (Intra Venous) -Intermittent meds: PICC/HICKMAN (SASH) : Using at least a 10 milliliter syringe flush with 10 ml Normal Saline before and after med then 5 ml flush (10 u/ml) heparin flush...."</p> <p>RN #4 indicated that she understood the MAR entry to mean they were to flush with normal saline and then heparin after they give an IV medication, such as the antibiotic. RN # 4 indicated the new MAR system was confusing and misleading. She indicated the PICC line had become clotted and they used Cath Flo (blood clot dissolving medication) to clean it out and that they were supposed to notify the physician if it had become clogged again.</p> <p>The physician's order on the computer indicated, "... IV -Intermittent meds: PICC [Peripherally Inserted Central Catheter] /HICKMAN [brand of catheter] (SASH) [Saline Administer medication Saline Heprain] : Using at least a 10 milliliter syringe flush with 10 ml NS before and after med then 5 ml flush (10 u/ml) heparin flush...."</p> <p>On 10/23/14 at 11:40 a.m., the ADON indicated the nurses need to know whether the doctor ordered heparin or not</p>			

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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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F000329 SS=D	<p>as it can be different at times. She indicated the MAR should indicate how they need to care for the PICC line.</p> <p>This Federal tag relates to Complaint IN00157731</p> <p>3.1-47(a)(2) 3.1-47(a)(3)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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 interview and record review, the facility failed to attempt interventions for behaviors prior to use of an</p>	F000329	F 329 Drug regimen is free from unnecessary drugs:	11/22/2014			

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	<p>antianxiety medication, have diagnosis for the use of an antipsychotic medication and have targeted behaviors for the use of an antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications in a sample of 5. (Resident J, #17 and Resident #168)</p> <p>Findings include:</p> <p>1. On 10/20/14 at 3:00 p.m., the record for Resident #168 was reviewed. Diagnoses included, but were not limited to, dementia, delusions, and depression.</p> <p>The behavioral notes documentation provided by the Social Services Director indicated: During the dates of 8/24/14 and 8/25/14, the resident had the following behaviors : Attempted to elope, had concerns related to staff assisting other residents and became agitated and yelling at staff because she feared the staff were harming the other residents. At times she would try to grab the staff, placing herself between the staff and the residents. She would Bang and yell at people outside. She would go into other resident's rooms and take their belongings, and thought other residents belongings were hers. She would yell at the staff when they attempted to provide care to other residents and raised her fist at them.</p>		<p>It is policy of Miller's Merry Manor that each resident's drug regimen be free of unnecessary drugs. This includes excessive doses, excessive duration of time, those used without adequate monitoring, or those without indications for use. It is also the policy of Miller's Merry Manor that the facility must ensure that residents using antipsychotic medications receive gradual dose reductions and behavioral interventions in an effort to discontinue these medication. All residents on psych medications within the facility have the potential to be affected by this deficient practice. The residents involved in the identified deficient practice did not experience any negative side effects. All nursing staff will be in-serviced on 11/7/14 on the "Behavior Assessment and Management Policy" (attachment 6a 1-2), the "Psychotropic Drug Use Policy" (attachment 6b 1-5), and the "Blood Glucose Monitoring Policy" (6c 1-2). For continued compliance the "Behavior and antipsychotic medication review" (6d 1-2) and "Blood Glucose Monitoring Review" (6e 1-2) QA Tools 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.</p>				

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	<p>The admission documentation to a behavioral unit dated 8/25/14, "...History and Physical Examination...Patient with aggression x 3-4 days. Also exit seeking. positive for hallucinations...Initial Assessment :...the patient was transferred from a facility in [name of city]. Apparently the patient had thrown a lamp through a glass window. She had been exit seeking, banging on doors. She had been yelling 'don't hurt me, you're hurting me' when nobody was around,. She also grabbed another patient's hand and held onto it. She had been seeing snow outside the window, was seeing balls on the rooftop. On 7/22/14 she began getting very agitated, hitting and grabbing an aide. She had to be given Haldol [an antipsychotic] 1 milligrams. Apparently the patient was just treated at [hospital name]. She was under the care of [physician name] for similar symptoms...Psychiatric Mental Status Examination...Thought Content: Some disorganized delusions, possible visual hallucinations...9/8/14 -Remeron [antidepression medication] 7.5 milligrams daily by mouth and Zyprexa [an antipsychotic medication] 5 milligrams by mouth twice daily...."</p> <p>The physician's orders dated 8/22/14, indicated, "...1) Risperidal [anti psychotic</p>		<p>These corrective actions will be completed by 11/22/14.</p>	

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	<p>medication] 0.25 milligrams twice a daily by mouth for 2 weeks 2) Haldol [anti psychotic medication] 1 milligrams IM [Intra Muscularly] for aggitation [sic] and aggression now, may repeat 1 milligrams IM Haldol in 2 hours...."</p> <p>The Inter Disciplinary Team evaluation dated 8/28/14 indicated, "...Physical Factors : Resident was assessed and no findings. Environmental Factors : Returned from [name of behavioral unit]., New Equipment/Procedures: N/A. New Medications/Treatments : Psych medication changes made while at [name of behavioral unit] daily and Intramuscular [antipsychotic medication]Haldol added as well. Family Factors: N/A. Summary/Plan of Action : Resident behavior has escalated and family was having to come in on a nightly basis. [Physician name] notified but did not think a visit back to [behavioral unit] was appropriate. Family and IDT decided resident should go to [another behavioral unit name] resident admitted 8/25/14...."</p> <p>The resident was admitted to the behavioral unit on 8/25/14 and returned to facility on 9/8/14. The physician's orders indicated the resident returned being on Zyprexa 5 milligrams twice daily for dementia.</p>			

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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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	<p>The behavior tracking for September and October 2014 indicated,"...Intervention/Task: Document mood behavior #1 : Anger at staff. Interventions : [1] Approach in calm friendly manner [2] Allow resident to express concerns and try and resolve concerns ASAP [3] Do not argue or try and reason [4] Leave safely and reapproach in 15 minutes..."</p> <p>On 10/22/14 at 4:10 p.m., the Social Services Director indicated she was not sure what the reason was for the resident to be on the Zyprexa. A request was made at that time for any information as to the diagnosis or reason as to why the resident was on Zyprexa.</p> <p>On 10/23/14 at 6:30 p.m., at the exit conference no more information was provided.</p> <p>2. On 10/20/14 at 9:00 a.m., Resident J's record was reviewed. Diagnoses included, but were not limited to, Alzheimers disease, unspecified psychosis, anxiety state, depressive disorder, and dementia with behavioral disturbances.</p> <p>The October 2014, Recapitulation orders included, but were not limited to: 9/10/14-Quetiapine Fumarate (Seroquel) Tablet (An antipsychotic medication) 50</p>				

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	<p>mg (milligrams) give one tablet by mouth twice daily for unspecified psychosis.</p> <p>A document titled, "Facility-Behavior/Psychotropic Med Quarterly Review" dated 3/27/14, indicated the resident received Seroquel twice a day. The diagnosis for this medication was unspecified psychosis, which was started on 12/28/11, prior to the resident's admission to the facility. The resident was delusional and having paranoia, so the medication was started. She was not being followed by a Psychiatrist or an outside mental health service. The specific targeted behaviors, which caused the resident to represent a danger to herself or others or caused an impairment in functional abilities was excessive nervousness/delusions that were evidenced by self isolation, crying, decreased appetite, refusal of care, restlessness, and increased confusion. The resident had an increased amount of wandering and confusion. The IDT (Intradisciplinary Team) had discussed the possibility of moving the resident to the dementia unit. The resident's Power of Attorney did not want to change anything at that time.</p> <p>A document titled, "Facility-Behavior/Psychotropic Med Quarterly Review" dated 5/22/14 at 3:09</p>						

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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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	<p>p.m., indicated the resident received Seroquel twice a day. The resident had originally started this medication on 12/28/11, prior to the admission to the facility. The diagnoses for the use of this medication was delusions and paranoia. The resident was not followed by a Psychiatrist or an outside mental health service. The specific targeted behaviors, which caused the resident to represent a danger to herself or others or caused an impairment in functional abilities was excessive nervousness/delusions as evidenced by: the resident isolated herself, tearfulness, decreased appetite, refusal of care, restlessness, and increased confusion. The frequency and evaluation of her behavioral issues were 16 documented behaviors over the last 90 shifts and 15 of 16 behaviors improved with the use of interventions. The resident had a diagnosis of dementia and behaviors and increased confusion was expected. The IDT (Interdisciplinary Team) thought the resident would do well on the dementia unit, however the resident's Power of Attorney would not consent to the move.</p> <p>The resident's Physician documented on the Progress Notes on the following dates: 12/1/13-indicated "...She states she is doing ok...A/p...4) Dementia-slow</p>			

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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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	<p>decline on Aricept + Namenda 5) Depression-Stable on Zoloft [An anti-depressant medication]."</p> <p>2/28/14-indicated "...She states that she is not doing good, but can't really say why. She seems more confused... A/p...4) Depression-stable on Zoloft 5) Dementia-Declining -on Aricept + Namenda."</p> <p>4/17/14-indicated "...She doesn't have any particular complaints... A/p... 5) Depression-stable on Zoloft."</p> <p>6/20/14-indicated "...A/p... 4) Depression-Stable on Zoloft...."</p> <p>8/29/14-indicated "...Stated that she was doing ok ... A/p ... 5) Depression-Stable Continue Zoloft."</p> <p>The resident's Annual MDS (Minimum Date Set) assessment dated 5/16/14, indicated her BIMS (Brief Interview for Mental Status) was a 4, which indicated severely cognitively impaired. The resident had not displayed any hallucinations, delusions, physical or verbal behaviors, wandering or any other behavioral symptoms in the last seven days during the assessment period.</p> <p>The resident's Significant Change MDS</p>						

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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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	<p>assessment dated 8/14/14, indicated her BIMS (Brief Interview for Mental Status) was a 3, which indicated severely cognitively impaired. The resident had not displayed any hallucinations, delusions, physical or verbal behaviors, wandering or any other behavioral symptoms in the last seven days during the assessment period.</p> <p>The resident's Significant Change MDS assessment dated 9/2/14, indicated her BIMS (Brief Interview for Mental Status) was a 3, which indicated severely cognitively impaired. The resident had not displayed any hallucinations, delusions, physical or verbal behaviors, wandering or any other behavioral symptoms in the last seven days during the assessment period.</p> <p>A document titled "Documentation Survey Report" indicated the resident had documented "mood behavior delusions such as her children and/or grand children are in eminent danger AEB [as evidenced by] increased wandering (looking for children and grandchildren), refuse care/meals, increase restlessness and agitation, sleeplessness." in the following Months: August 2014: 14 times September 2014: 3 times October 2014 until 10/22/14: 4 times</p>			

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	<p>March 2014 through October 2014 Behavior Monitoring Logs was requested on 10/22/14 at 5:10 p.m.</p> <p>At the end of the exit conference on 10/23/14 at 6:30 p.m., no further information was provided on the residents Behavior Monitoring logs for March 2014 to July 2014.</p> <p>The residents specific targeted behaviors that she was displaying was not clearly identified on the "Documentation Survey Report" to indicate if she was having delusions or not.</p> <p>The resident had a Care Plan dated 8/19/14, that addressed a problem she displayed mood issues exhibited by delusions as evidenced by she believed her children or grandchildren were in danger, self isolation, tearfulness, decreased appetite, refusal of care, restlessness and increased confusion.</p> <p>The intervention and tasks included, but were not limited to, "1/12/14--Administer psych medication as ordered, Monitor medication side effects at least daily on psychotropic medication record, Notify physician as needed, Provide support and encouragement PRN, SS to visit PRN, Psych Services to follow resident as</p>			

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	<p>needed, Document mood behavior #1 delusions AEB: Belief that her children or grandchildren are in danger, self isolation, tearfulness, decreased appetite, refusal of care, restless, increased confusion:[1] Provide support, encouragement and TCL [2] Remind Res of meal times and activities of the day and encourage participation. [3] Offer snack and/or beverage [4] Redirect to an activity of Res interest. Res enjoys playing the piano."</p> <p>During an interview on 10/22/14 at 4:20 p.m., the Social Service Director indicated the resident's specific targeted behavior that was being monitored for the Seroquel was delusions, but she had not been having delusions. The resident's Behavior Tracking Log indicated the specific targeted behavior being monitored, but did not allow documentation of the way she displayed that behavior, only the number of times the behavior occurred, what precipitated the behavior and what interventions were effective in improving the behavior.</p> <p>3. The record for Resident # 17 was reviewed on 10/20/14 at 1:34 p.m. Current diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>Physician orders for October 2014,</p>			

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	<p>indicated an order for Ativan (anti-anxiety) 0.5 milligrams (mg) two times daily as needed for anxiety with an original order date of 9/4/14. The orders also included an order for blood sugar checks 2 times daily on Monday, Wednesday and Friday with an original order date of 9/5/14.</p> <p>The June and August 2014, Medication Administration Records (MAR) lacked results of blood sugar checks on June 25, 27, August 11, 13 and 15 at 4 p.m.</p> <p>A plan of care dated 4/25/14, indicated a focus of PRN (as needed) Anxiolytic (anti-anxiety medication) with approaches that included, but were not limited to, Address physical needs, change environment, redirect thoughts, and social service to visit as needed providing support.</p> <p>The August 2014, MAR indicated Ativan was given on the 18, 19 and 23. The September MAR indicated the Ativan was given on the 1st. The "PRN Sheet" for August and September 2014, indicated Ativan was given on August 18, 19, 23, 28, September 1, 4, and 7. The sheet indicated the Ativan was given for agitation, restless or anxiety. There was no documentation on this form as to what behavior/mood she was exhibiting</p>			

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 10/23/2014
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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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	<p>or what interventions were attempted prior to the the administration of the medications.</p> <p>The "PRN Anxiety Protocol" section of the medication sheet indicated: "...Address physical needs...change environment...redirect thoughts...all of the above. Results: I=Ineffective; E=Effective." This section of the August and September MAR was blank.</p> <p>The progress notes and behavior documentation lacked any behavior/mood indication for the use of the Ativan for the above listed dates.</p> <p>Additional information was requested from the DON on 10/21/14 at 11:14 a.m., regarding the above missing blood sugar results and the prior interventions for the administration of Ativan.</p> <p>During interview on 10/21/14 at 2:41 p.m., the DON indicated she was unable to locate the blood sugar results for the above listed dates and she could not find any additional information regarding the behaviors for use or the prior interventions implemented for the administration of the as needed Ativan for the above given doses.</p> <p>A policy titled "Psychotropic Medication</p>			

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	<p>Use" was provided by the Director of Nursing on 10/21/14 at 1:15 p.m., and deemed as current. The policy indicated: "...Purpose: ...non-pharmacological interventions are considered and used when indicated instead of, or in addition to, medication..." A table in the policy in the heading "Antipsychotic...Behavior Monitoring Specific target behaviors which cause the resident to represent a danger to self or others or cause the resident distress and impairment in functional ability. OR symptoms are identified as being due to mania or psychosis (Such as: auditory, visual, or other hallucinations; delusions [such as grandiose or paranoia]). Episodes will be documented in the clinical record as they occur along with the results of the interventions used to reduce the behavior or symptom...Anxiolytic...Behavior Monitoring...Target behaviors must be clearly identified and monitored. Episodes will be documented in the clinical record as they occur...."</p> <p>A policy titled "Blood Glucose Monitoring" was provided by the Director of Nursing on 10/21/14 at 1:15 p.m., and deemed as current. The policy indicated: "...Policy: it is the policy...to monitor blood glucose per physician's orders...."</p>			

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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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F000333 SS=G	<p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure the correct medication was given, causing hallucinations, confusion and combativeness, resulting in an emergency room visit for 1 of 6 residents reviewed for medication errors in a sample of 6 residents. (Resident Q)</p> <p>Findings include:</p> <p>On 10/23/14 at 2:50 p.m., the Director of Nursing (DON) provided three Medication Error Reports for the period of 9/21/14 through 10/4/14.</p> <p>On 10/23/14 at 3:30 p.m., the record review for Resident Q was completed. Diagnoses included cancer, UTI's, and depression.</p> <p>A request was made to the Director of Nursing for medication errors for the last two weeks of September and the first two weeks of October. Three medication error reports were reviewed.</p>	F000333	<p>F 333 Residents free of significant med errors: It is policy of Miller's Merry Manor that all medications are given per the physicians order including Right resident, right medication, right dose, right route, and right time. All residents within the facility have the potential to be affected by this deficient practice. The resident involved in the identified deficient practice did not experience any lasting effects. All nursing staff will be in-serviced on 11/7/14 over the "Medication Administration Procedure" (7a 1-2). Each nurse in the facility is to be observed and checked off to validate their understanding of the application of these policies using the "Medication Pass Procedure" (7b). For continued compliance this QA tool will be completed randomly and 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</p>	11/22/2014	

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	<p>The document titled, "Medication and Treatment Error Report" for Resident Q indicated, "...Date and time of error: 10/3/14 at 2 p.m....Medication/Treatment Involved: Ambien 30 milligrams...Explanation of error: Resident was given Ambien [a sleep medication] 10 milligrams x 3 instead of Methadone [a pain medication]100 [sic] milligrams x 3...Negative Outcomes from Error : Resident with increased hallucinations, increased combativeness, increased restlessness, and increased confusion. Action Taken for Resident :Attempted to redirect resident multiple times unsuccessfully, sent resident to [hospital name] for evaluation and treatment..."</p> <p>The Assessment dated 10/3/14 6:30 p.m., indicated the physician was notified and an order received to transfer the resident to the hospital or other health care setting. The resident was sent to (hospital name) by ambulance. The reason for the transfer: 30 milligrams Ambien given. The resident returned to the facility on 10/3/14 at 9:00 p.m.</p> <p>The Medication Administration Record (Medication Administration Record) for October 2014 indicated, "... Ambien 5 milligrams every hours of sleep as</p>		<p>completed by 11/22/14. Miller's Merry Manor-Tipton is requesting an IDR of F-Tag 333 with the scope and severity of G. Through the IDR process the facility is seeking to have tag deleted completely or at the very least the scope & severity reduced. The facility is seeking to IDR this tag due to additional information not being considered during the initial survey process. This information was available at the time of the survey, however was not presented to the surveyor due to the fact it was never requested as well as the fact that the surveyor did not clearly explain on what basis the deficiency was being cited. Please note that the CMS 2567 indicates that the facility ensures that residents are free from any significant medication errors. No facility can ensure that medication errors will never occur nor do the regulations mandate that a facility prevent all medication errors. In fact the regulation 483.25(m)(1) indicates that the facility ensure that it is free from medication error rates of 5% or greater. The regulation for F-Tag 333 indicates that there are three things to consider when determining medical significance. The first thing to consider is the resident's condition. The medication Resident "Q" received in error was an ordered medication for this resident. Resident "Q" was sent to IUTH as a precaution per Doctors orders.</p>		

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	<p>needed (9/8/14)... Methadone 10 milligrams (3 tablets at 6 am, 2 pm and 10 pm...." There were initials inside the Methadone 30 milligrams box for 2 p.m. and the order for the Ambien had no signature inside of the box. The nurse who gave the medication was unable to be identified.</p> <p>On 10/22/14 at 4:45 p.m., the DON indicated according to the nurse who gave the medications , the nurse indicated the medications were bundled together with a rubber band. The nurse read the label for the medication of Methadone, and when she punched the pills out, she punched the pills out of the Ambien card instead. The nurse did not realize this until after the medication was given. The DON indicated there was no other action taken other than a Medication Error Report.</p> <p>This Federal tag relates to Complaint IN00157731.</p> <p>3.1-25(b)(9)</p>		<p>Resident "Q" condition required no significant medical intervention and did not require admission to the hospital for intensive monitoring or hospital level of care. The second thing to consider is the category of the medications administered in error. This medication does not require any routine monitoring for level management and does not have a Narrow Therapeutic Index, does not require titration to a specific blood level that could alter levels causing toxicity etc..</p> <p>Overdose symptoms may include sleepiness, shallow breathing, feeling light-headed, fainting, or coma of which resident "Q" did not exhibit. The third thing to consider is the frequency of the error. This was a one time occurrence and had no lasting side effects. In conclusion, we feel that this error was not a significant medication error. Resident "Q" was sent out to the hospital as a precaution at 6:30pm and returned to the facility at 9pm (2 ½ hours total). Resident "Q" returned with no new orders. Resident "Q" had no lasting side effects to the medication, was back to her normal self less than 12 hours later and was able to successfully discharge home as planned on 10/9/14. Therefore, we feel that the evidence explained above explains why F-tag 333 is not an appropriate citation and we respectfully ask that it be</p>		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p>		removed, or at a minimum, lowered in scope and severity.	

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	<p>of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing personal washed their hands for the appropriate amount of time during a meal service in 1 of 3 dining rooms and staff member failed to wash her hands while giving personal care for 1 of 5 resident care observations for handwashing. (Resident O)</p> <p>Findings include:</p> <p>1. On 10/15/14 the following were observed during a lunch observation:</p> <p>At 12:03 p.m., LPN # 10 was observed washing her hands for 10 seconds then served residents drinks for lunch.</p> <p>At 12:40 p.m., CNA # 19 was observed washing her hands for 12 seconds, then she went to feed Resident # 51 and cut up Resident J's spaghetti.</p> <p>2. On 10/21/14 at 4:45 p.m., CNA # 6 was observed giving pericare to Resident O. After CNA # 6 gave pericare to the resident she replaced his brief, pulled up his pants and covered him up with his blankets. She gathered the trash and removed her gloves. She left the resident's room without washing her hands, took the trash to the soiled utility</p>	F000441	<p>F 441 Infection Control, Prevent Spread Linens:</p> <p>It is the policy of Miller's Merry Manor to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. All residents within the facility have the potential to be affected by this deficient practice. None of the residents involved in the identified deficient practice experienced any negative side effects or outcome. All staff will be in-serviced on 11/7/14 which will include the review of "Use of Medical Gloves" (8a 1-2) and "Hand Washing and Hand Asepsis Policy" (8b 1-2). Each staff member is to be observed and checked off to validate their understanding of the application of these policies. To ensure ongoing compliance with the corrections, the Infection Control Nurse, Director of Nursing or other designee will be responsible for completing the QA Tool entitled "Infection Control/Glove Use Review"(8c 1-2) weekly for 4 weeks then monthly for 2 months and quarterly thereafter, whereas no fewer than 10 facility employees, including employees from all shifts, will be selected to observe and check off for infection control</p>	11/22/2014

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	<p>room, went to the clean supply closet and obtained a spray soap bottle and went back to the resident's room. She donned a clean pair of gloves without washing her hands and gave him pericare using the spray bottle of soap.</p> <p>During an interview on 10/21/14 at 5:06 p.m., CNA # 6 indicated she should have washed her hands after she removed her gloves in the resident's room or at least in the soiled utility room after she threw the trash away.</p> <p>During an interview on 10/21/14 at 6:15 p.m., the Administrator indicated the staff was to wash their hands for 20 seconds. He indicated CNA # 6 should have washed her hands after she removed her gloves.</p> <p>A current policy titled "Handwashing" dated 01/30/2013, provided by the Director of Nursing on 10/21/14 at 11:00 a.m., indicated "...2. PROCEDURE:... D. Rub hands vigorously together for 20-30 seconds with attention paid to areas underneath the fingernails and between the fingers...."</p> <p>3.1-18(l)</p>		<p>practices. Results of all skills validations checks, including random infection control observations, will be discussed at monthly QA committee meetings and any identified trends or new concerns will be addressed by the committee appropriately. Any concerns identified during infection control skills observations will also be addressed individually at the time of the occurrence. Corrective action will be completed by 11/22/14.</p>		