

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 4, 5, 6, 7 and 8, 2016.</p> <p>Facility number: 000578 Provider number: 155627 AIM number: 100267810</p> <p>Census bed type: SNF/NF: 21 Total: 21</p> <p>Census payor type: Medicare: 1 Medicaid: 17 Other: 3 Total: 21</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on January 12, 2016.</p>	F 0000	<p>To Whom It May Concern,</p> <p>Please accept the enclosed plan of correction as credible allegation of compliance for each deficiency cited during the annual Indiana State Department of Health Survey conducted on January 8, 2016. We respectfully request consideration for paper compliance for our submitted plan of correction. Should you have any questions or need additional information, please do not hesitate to contact me at 260-563-4112.</p> <p>Sincerely, Amanda Harris, HFA Administrator</p>	
F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p>			

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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	<p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure assistive devices were accessible to 1 of 19 residents reviewed. (Resident #20)</p> <p>Findings include:</p> <p>On 1/5/16 at 11:31 a.m., Resident #20 was observed sitting on the edge of his bed. He indicated he was waiting for lunchtime. There was no walker or wheelchair visible in the resident's room.</p> <p>On 1/6/16 at 9:19 a.m., Resident #20 was observed in bed sleeping. There was no walker or wheelchair visible in the resident's room.</p> <p>On 1/7/16 at 8:13 a.m., Resident #20 was observed in bed sleeping. There was no walker or wheelchair visible in the resident's room.</p> <p>Review of Resident #20's clinical record began on 1/5/16 at 9:21 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance,</p>	F 0242	<p>F242: It is the policy of Miller's MerryManor Wabash West that the resident has the right to choose activities,schedules, and health care consistent with his or her interests, assessments,and plans of care: interact with members of the community both inside andoutside of the facility; and make choices about aspects of his or her life inthe facility that are significant to the resident.</p> <p>Resident #20: Resident #20 continues to reside inthe facility. Resident has Dementia and thus lack of safety awareness. Therapy evaluation was requested for resident.Resident is currently receiving PT and OT. Therapy will be working withresident in hopes of improving ability to self transfer. Therapy will also beevaluating use of the walker. A flat soft mat has been placed by the resident'sbedside for safety. Anti-rollback device has been applied to W/C. Utilizationof bed/chair alarm will be implemented temporarily while in therapy. Furtherchanges to plan of care will be made after treatment is completed in therapy. Allresidents requiring the use of</p>	02/07/2016

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	<p>unspecified mood disorder, insomnia, and difficulty walking.</p> <p>Resident #20 had a 10/13/15, admission Minimum Data Set assessment (MDS), which indicated the resident was moderately cognitively impaired, required extensive assistance with transfers, and used a walker and wheelchair for mobility.</p> <p>Resident #20 had a current care plan problem of risk for falls. Interventions included, but were not limited to, "keeping the wheelchair and walker out of sight when in bed and to encourage assistance with transfers."</p> <p>Review of a progress note, dated 1/3/16, Resident #20 indicated he felt depressed due to his wheelchair not being accessible to him at all times.</p> <p>Review of a "Physical Therapy Plan of Care" document, dated 10/7/15, indicated the resident's level of ability for transfers was with contact guard assist.</p> <p>Review of a "PT- Therapist Progress Note & Discharge Summary", dated 11/19/15, indicated Resident #20 had not improved his functional status, but had been educated on safe transfers, toileting tasks and the use of grab bars in the</p>		<p>assistive devices for care have been reviewed to ensure that proper devices are available for use per the resident's choice. No other issues were identified.</p> <p>Staff re-educated regarding resident's right to make choices on 1-22-16.</p> <p>The facility will attempt the less restrictive of interventions when addressing residents with falls to ensure resident's safety and to allow them to maintain highest functioning.</p> <p>To ensure ongoing compliance the DON/Designee will complete the audit tool "Fall Evaluation" (Attachment A). This tool will be completed weekly x 4 weeks then monthly thereafter to ensure residents have needed assistive devices available and that appropriate interventions are implemented when falls do occur. Any identified issues will be addressed and logged on the "Quality Improvement Summary Log" (Attachment B). The logs will be reviewed and changes made as needed through the monthly Quality Improvement meeting to ensure ongoing compliance.</p> <p>Date of Compliance: 2-7-16</p>	

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	<p>bathroom.</p> <p>Review of "Initial Occurrence" documents, indicated the resident had falls on the following dates:</p> <p>On 11/15/15, Resident #20 had slid from the edge of his bed.</p> <p>On 11/18/15, Resident #20 had been found on his restroom floor after attempting to transfer himself from his wheelchair.</p> <p>On 11/20/15, Resident #20 fell while transferring himself to his wheelchair.</p> <p>On 11/28/15, Resident #20 had returned to his room by himself and was found on the floor next to his wheelchair.</p> <p>On 12/25/15, Resident #20 was found on the floor in his doorway. There was no documentation as to where his wheelchair was located.</p> <p>During an interview, on 1/7/15 at 10:51 a.m., the DON indicated Resident #20 was able to transfer himself, but was not steady, therefore his wheelchair was removed from his room for safety while the resident was in bed. He further indicated no other interventions had been tried, as the facility felt the resident</p>			

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	<p>attempted to self-transfer when he saw his wheelchair.</p> <p>During an interview, on 1/7/16 at 2:26 p.m., PTA #5 indicated Resident #20 was not compliant with instructions for transfers and did not use his call light to ask for assistance. He indicated he felt it was safer for the resident to have waited in bed for help than to fall while transferring himself. He again indicated the resident would not use his call light, so not having the wheelchair nearby prevented the resident from attempting to get up by himself. He indicated he had not worked with the resident since November 2015. He indicated he was not aware of any other interventions, such as a personal alarm, being used to encourage the resident to wait for assistance.</p> <p>During an interview, on 1/7/15 at 2:43 p.m., CNA #10 indicated Resident #20 could transfer with someone standing next to him for support.</p> <p>During an interview, on 1/8/16 at 9:04 A.M., CNA #8 and LPN #3 indicated the resident could transfer with someone standing next to him. CNA #8 indicated Resident #20 used the grab bars in the bathroom to transfer to and from the wheelchair. She further indicated the</p>			

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F 0309 SS=D Bldg. 00	<p>resident was physically able to ambulate with a walker and assist of two staff members. LPN #3 indicated she was not aware of the resident using a walker and he was always transferred to the toilet with the wheelchair. They indicated the resident's wheelchair was kept in the hallway to prevent the resident from falling while transferring himself.</p> <p>During an interview, on 1/8/16 at 9:35 a.m., the DON indicated the resident was not ambulated to the bathroom with a walker, as it took two staff members to assist the resident and it was difficult to move in the bathroom. He further indicated the therapy department had advised to not use the walker. He indicated he was not aware the resident's careplan included using a walker to ambulate to the bathroom.</p> <p>3.1-3(u)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review,</p>	F 0309	F309 Provide Care/Services for	02/07/2016			

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	<p>the facility failed to ensure behaviors were identified, treated with non-pharmacological interventions, and monitored for unnecessary medications for 2 of 5 residents being treated for dementia and reviewed for unnecessary medications. (Residents #20 and #9)</p> <p>Findings include:</p> <p>1. Review of Resident #20's clinical record began on 1/5/16 at 9:21 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, unspecified mood disorder, insomnia, and difficulty walking.</p> <p>Resident #20 had a 10/13/15, admission Minimum Data Set assessment (MDS), which indicated the resident was moderately cognitively impaired and had not experienced behaviors during the assessment period.</p> <p>Resident #20's current medications included, but were not limited to, lamotrigine 100 mg (a mood stabilizer) twice daily, Trazodone 75 mg (an antidepressant) at bedtime, and olanzapine 5mg (an antipsychotic) in the morning and 10 mg at bedtime, and Lexapro 10 mg (an antidepressant) daily.</p> <p>Review of a Behavior Tracking document</p>		<p>highestWell Being: It is the policy of Miller's Merry Manor, Wabash West to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Resident #9: Resident #9 remains in the facility. Resident currently has no PRN medication ordered for behaviors. Resident's current psychoactive medications have been reviewed along with the behavior monitoring that is in place. Psych services will continue to follow resident for management of her psychoactive medications.</p> <p>Resident #20: Review has been completed of resident's current psychoactive medications. Have clarified reason for use and also target behaviors for all psychoactive medication administered. Care plans and behavior monitoring have been reviewed and updated as needed. SSW has completed new Behavior/Psychotropic Medication Quarterly Review Assessment.</p> <p>Resident continues to receive trazadone 75mg at hs. This medication is ordered for sleep. Although trazadone is in the anti-depressant category, it is also indicated for insomnia. In fact, trazadone is generally only effective for anti-depressant use in dosages of 150mg and greater</p>	

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	<p>for October, 2015 indicated behavior monitoring did not begin for Resident #20 until 10/16/15. There were three episodes of Resident #20 believing someone had taken items from him on the following dates: 10/17/15, 10/20/15, and 10/25/15. The instances were resolved by redirecting the resident and locating the item. There were no other behaviors documented in the resident's clinical record, from his admission on 10/6/15 through 10/26/15, when the psychiatric evaluation was completed.</p> <p>Review of a "Behavior/Psychotropic Med Quarterly Review", dated 10/9/15, indicated the resident's target behavior was depression for the use of olanzapine. The lamotrigine use was not reviewed.</p> <p>Review of a "Rounding Providers Psych Progress Note", dated 10/26/15, indicated an initial psychiatric evaluation was completed on this date. The note indicated the resident was having behaviors of aggression with staff, inappropriate urination, and yelling and cursing. An order was written to increase Resident #20's lamotrigine 100 mg from once daily to twice daily.</p> <p>Review of a "New Behavior Assessment", dated 10/28/15, indicated Resident #20 had asked a housekeeper if</p>		<p>(Attachment C). Therefore, this is not considered duplicate therapy for depression. The facility will continue monitoring per policy. Psych services will continue to follow resident.</p> <p>All residents receiving psychoactive medication for behavior/mood have the potential to be affected. All have been reviewed to ensure that medication has appropriate diagnosis for use, proper behavior tracking is in place, and care plans include non-pharmacological interventions.</p> <p>The facility will re-educate all staff regarding the facility policy for the use of psychoactive medication, the required documentation and monitoring that must be completed.</p> <p>Additional training has been provided for the SSW from the Regional Social Services Consultant regarding documentation guidelines and the P/P for psych medication monitoring.</p> <p>To ensure this does not reoccur the DON/Designee will complete the QA tool "Behavior Antipsychotic Medication Review" (Attachment D) monthly x3 and then quarterly thereafter. Any identified issues will be addressed immediately and logged on the "Quality Improvement Summary Log" (Attachment B). This will be followed and reviewed through</p>		

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	<p>she wanted to get into bed with him and a CNA to remove her shirt. The note indicated the resident was easily redirected. The note further indicated on an undated follow up assessment the resident told a staff member to "Shut up" when the resident was found in the hallway undressed with a wet brief on. The note indicated the resident was easily redirected.</p> <p>Review of an "Activity- Admission/Annual/Significant Change Assessment", dated 10/9/15, indicated Resident #20 was not interested in group activities and preferred to stay in his room.</p> <p>"Medication Change Follow-up Assessment (New or Dosage Change)" documents, dated 10/28/15 through 11/1/15, indicated no changes in mood or behavior during the assessment period following the increase in the lamotrigine.</p> <p>Review of a Behavior Tracking document for November, 2015 indicated Resident #20 had 9 episodes of a behavior listed as either sexual statements or yelling/cursing at staff between 11/5/15 and 11/30/15. There was no indication as to which behavior had occurred.</p> <p>A "Rounding Providers Psych Progress</p>		<p>the monthly facilityQuality Assurance Improvement meeting. Date ofCompliance: 2-7-16</p>				

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	<p>Note", dated 12/28/15, indicated the resident was in bed sleeping at the time of the exam, but was easily awakened and denied depression.</p> <p>Review of a "Behavior/Psychotropic Med Quarterly Review", dated 12/31/15, indicated the resident's target behavior was depression for the use of olanzapine. The lamotrigine use was not reviewed.</p> <p>Review of an "Activity- Quarterly Assessment", dated 12/30/15, indicated Resident #20 did not participate in activities, preferred to be in his room, and visited with another resident at meals.</p> <p>Resident #20 had a current careplan for activities, which indicated the resident preferred to not attend activities due to having had a long history of "...not being very social/loner...."</p> <p>A "Social Service Assessment", dated 12/31/15, indicated Resident #20 was exhibiting signs of mild depression, largely due to having trouble sleeping at night.</p> <p>Resident #20's progress notes, for the dates of 12/31/15 through 1/5/16 indicated the following:</p> <p>On 12/31/15, the Social Services Director</p>			

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	<p>contacted Resident #20's family regarding motivating the resident. The note indicated Resident #20's only interest in years past was "of coming home and drinking with no other interest".</p> <p>On 1/3/16 at 12:07 p.m., Resident #20 indicated he felt depressed due to not having access to his wheelchair. The note further indicated the wheelchair was kept from him to prevent falls.</p> <p>On 1/4/16 at 12:58 a.m., Resident #20 was asked if he may have felt depressed and answered yes.</p> <p>Eight other progress notes during this time period indicated Resident #20 denied depression, was pleasant and cheerful, and spent most of his time sleeping, which was usual behavior for him.</p> <p>Review of the clinical record indicated an order was received on 1/6/16 for Lexapro 10 mg for depression.</p> <p>During an interview, on 1/7/16 at 9:47 a.m., the Social Services Director (SSD), indicated Resident #20 had removed himself from socialization, only came out for meals, and was not a "self-motivated individual". She further indicated the</p>			

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	<p>resident's family indicated this was his normal behavior. She further indicated she had pursued having Resident #20 started on an antidepressant medication due to his assessment showing mild depression. She indicated she was not aware Trazodone was an antidepressant, as it was being used for insomnia.</p> <p>During an interview, on 1/7/16 at 10:50 a.m., the DON indicated Resident #20's lamotrigine was increased on 10/26/15 due to increased behaviors. When asked about the lack of behaviors documented in the clinical record, the DON indicated the medication was increased due to behaviors that occurred prior to admission to the facility, and had occurred at the resident's previous facility.</p> <p>During an interview, on 1/7/16 at 10:50 a.m., the DON and Nurse Consultant indicated the sexual behavior and yelling at staff should have been separated, as there was no way to differentiate between which behavior had occurred.</p> <p>During an interview, on 1/8/16 at 8:40 a.m., the psychiatric nurse practitioner indicated Resident #20's lamotrigine had been increased due to being informed the resident was feeling angry, had yelled at staff, and had been urinating on the floor.</p>			

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	<p>When asked about documentation regarding these behaviors, she indicated the facility had informed her verbally that the behaviors had occurred. She indicated there was a note from the resident's primary care provider that referenced his urinating in inappropriate places, but did not relaise it was after the date the lamotrigine had been increased. She further indicated she had been informed by the facility of Resident #20's depression screening results and that there was documentation of the resident voicing depression. She indicated she was not aware there were two instances documented and one was voiced due to not having access to his wheelchair.</p> <p>2. The clinical record for Resident #9 was reviewed on 1/6/16 at 9:16 a.m. Diagnoses for the resident included but were not limited to, anxiety, unspecified dementia with behavioral disturbance, bipolar disorder, schizophrenia, insomnia and mood disorder. The quarterly Minimum Data Set (MDS) assessment, dated 11/18/15, indicated Resident #9 had a moderate cognitive impairment</p> <p>Review of the June 2015 "Progress Notes" for Resident #9 indicated the following:</p> <p>6/10/15 at 12:30 p.m. "...Type: General Note...Res [resident] is very verbal,</p>			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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	<p>swearing @ [at] everyone who comes close to her stating, 'I don't feel very good. I'm mad. I feel like I could hit somebody. I'll beat your fu----a--, b----. I just need to get out of this place. I'm sorry, I can't control myself, it is part of my sickness. I'm tired of being nice to everyone. I'll show them what a fu----- bi--- I can be....'"</p> <p>6/10/15 at 1:18 p.m. "...Type: Physician order (new or change)...rounding providers notified of resident having increased agitation and behaviors. New orders received for UA [urinalysis] C&S [culture and sensitivity] if indicated...and Ativan 0.5 mg [milligrams] po [by mouth] BID [twice a day] x [times] 7 days PRN [as needed] for agitation...."</p> <p>6/10/15 at 10:23 p.m. "...General Note...Labs came in showing 1+ bacteria, nitrate negative...New orders given to start macrobid [an antibiotic medication used to treat urinary tract infections] due to increased behaviors...."</p> <p>6/16/15 at 2:38 p.m. "...Physician order (new or change)...New order received...for Ativan 0.5 mg po BID for agitation/anxiety. Order received d/t [due to] resident at times continues to have agitation."</p>			

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	<p>The current health care plan assessment, with a revision date of 7/1/15, indicated Resident #9 had a problem with behaviors exhibited by the following: "...Resident displays mood issues exhibited by: Dx [diagnosis] [of] Bipolar, ...Schizophrenia, ...Delusions...Screaming at staff over delusional thoughts: Thinking others are talking about her...6/10/15 [Resident #9] had [an] increase in agitation, mania; change in psych [psychiatric] meds. Resident returned from... inpatient psych services on 6/30/15."</p> <p>Interventions for the problem included but were not limited to, "Document mood behavior #1: Screaming at staff over delusional thoughts: Thinking others are talking about her) Interventions: [1] approach calmly with a smile. [2] Listen to resident concern. [3] Do not challenge delusion/Calmly redirect res [resident] and offer reassurance. [4] Offer 1:1 [5] Offer outtings...." No resident specific interventions were documented. The care plan for the problem titled "Behavior" was originally initiated on 6/27/13.</p> <p>Resident #9's "PRN [medication] Sheet" was provided by the Director of Nursing on 1/6/16 at 3:00 p.m. This was compared to the Behavior Tracking Sheet for June, 2015. The "Behavior Sheet"</p>			

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	<p>indicated no behaviors on 6/11/15, 6/15/15, and 6/16/15.</p> <p>The resident received Ativan 0.5 mg. two times on 6/10/15. No prior non-pharmacological interventions were documented or whether medication effective or not on the PRN sheet. The behavior sheet indicated, on 6/10/15, two behaviors were noted. One behavior on day shift with non-pharmacological interventions documented as ineffective and one behavior on evening shift with non-pharmacological interventions documented as effective.</p> <p>In addition, review of the medication administration sheets for June, 2015 indicated Resident #9 had received "as needed" Ativan 0.5mg by mouth on 6/11/15 with no behavior documented or interventions used.</p> <p>The resident received Ativan 0.5 mg. twice on 6/12/15. No prior non-pharmacological interventions were documented on the prn sheet. On 6/12/15, two behaviors were noted on the behavior sheet with non-pharmacological interventions documented as effective.</p> <p>The resident received Ativan 0.5 mg on 6/14/15 at 10 p.m. for agitation. No prior non-pharmacological interventions were</p>				

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	<p>documented on the prn sheet. On 6/14/15, there was no behavior at 10:00 p.m. or the evening shift documented on the behavior sheet. No progress note for 6/14/15 as well.</p> <p>The resident received Ativan 0.5 mg twice on 6/15/15 for agitation. No prior non-pharmacological interventions were documented on the prn sheet. No behaviors were documented on the behavior sheet.</p> <p>The resident received Ativan 0.5 mg. twice on 6/16/15 for agitation and feeling "jittery." No prior non-pharmacological interventions were documented on the prn sheet. No behaviors were charted on the behavior sheet for 6/16/15.</p> <p>The resident received Ativan 0.5 mg. twice on 6/17/15 for agitation, "Rocking in chair," and verbal aggression. No prior non-pharmacological interventions were documented on the prn sheet. On 6/17/15, one behavior was noted on the behavior sheet with non-pharmacological interventions documented as effective.</p> <p>On 6/18/15 at 5:20 a.m. for agitation. No prior non-pharmacological interventions were documented on the prn sheet..</p> <p>During an interview with the Nurse</p>			

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	<p>Consultant and the Director of Nursing on 1/6/16 at 1:40 p.m., the Nurse Consultant indicated non-pharmacological interventions should have been tried prior to the administration of the prn Ativan for Resident #9 in June, 2015. The Nurse Consultant further indicated the nurses should also have documented whether the interventions were successful or not. She indicated the nurses did not document the information on the prn medication administration sheet.</p> <p>During an interview with LPN #7 on 1/6/16 at 1:13 p.m., she indicated new behaviors are typically documented in the progress notes and any other behaviors on the behavior tracking sheet. LPN # 7 indicated it would list the behavior, possible reason of behavior, interventions, and whether the interventions were successful or not.</p> <p>During an interview with LPN #7 on 1/6/16 at 1:51 p.m., she indicated prior to the administration of prn Ativan for Resident #9 she would attempt some non-pharmacological interventions such as: Offer a snack and talk or sit with the resident. She indicated the resident loved snacks. LPN #7 further indicated she might to offer to call the resident's daughter, so the resident could speak to</p>			

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	<p>her and at other times the resident just liked to be alone.</p> <p>The policy titled "Behavior Assessment & Management", with a policy start date of 10/27/14, was provided by the Director of Nursing on 1/6/16 at 3:00 p.m. It indicated the following:</p> <p>"...Prupose [sic]: ...The facility will document observation of these behaviors in the clinical record and gather evidence that other possible reasons for the distress or behavior have been considered... ...New Behavior Assessment Procedure: ...Interventions will be established in an effort to enhance staff approach to manage and assist in reducing or eliminating the problem behaviors. Non-medication interventions must always be attempted and evaluated prior to the initiation of psychoactive medications... ...If ineffectiveness is noted the IDT [interdisciplinary] team will be responsible to review and update the plan of care with new interventions...."</p> <p>The policy titled "PSYCHOTROPIC MEDICATION USE", with a policy start date of 2/4/08, was provided by the Director of Nursing on 1/6/16 at 3:40 p.m. It indicated the following:</p>				

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	<p>"...Psychotropic Drug Use: Purpose: To ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being...each resident receives only those medications, in doses and for the duration clinically indicated to treat th[e] resident's assessed condition(s); non-pharmacological interventions are considered and used when indicated, instead of, or in addition to medication; Clinically significant adverse consequences are minimized; and the potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Psychotropic medications will only be used when medically indicated to treat a specific condition... ...Procedure: ...3. ...Drug...ANXIOLYTIC [an anti-anxiety medication]...Behavior monitoring...Target behaviors must be clearly identified and monitored. 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...."</p> <p>No further information provided at time</p>			

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F 0329 SS=D Bldg. 00	<p>of exit on 1/8/16.</p> <p>3.1-37(a)</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 observation, interview and record review, the facility failed to utilize an antidepressant (Lexapro) based on need instead of a family member's request and did not provide any mood monitoring for 1 of 5 residents reviewed for unnecessary medication. (Resident</p>	F 0329	F-Tag329: Unnecessary Medications: It is the policy of Miller's Merry Manor, Wabash West that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive	02/07/2016	

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	<p>#24)</p> <p>Findings include:</p> <p>A review of the medical record for Resident #24 began on 01/06/2015 at 9:30 a.m. Diagnoses included, but were not limited to: insomnia, Diabetes Mellitus type 2, hypertension, chronic kidney disease, anxiety disorder and unspecified mood disorder. A review of the most recent Minimum Data Set assessment(MDS), dated 12/05/2015, indicated that Resident #24 was cognitively intact.</p> <p>During an observation and interview with Resident #24 on 01/07/2016 at 8:40 a.m., he was lying in his bed with the television on. He smiled and was pleasant and calm throughout the interview. He indicated that he was only down sometimes and that he did not know he was taking an medication for depression or why he would be taking one. Resident #24 was hopeful to be getting his prosthetic legs and returning home.</p> <p>During an interview with the Social Services Director (SSD) on 01/06/2016 at 2:02 p.m., she indicated that Resident #24 was taking Lexapro. She also indicated that each time Resident #24</p>		<p>dose,without adequate indication for use, or in the presence of adverse consequenceswhich indicate the dose should be reduced or discontinued; or any combinationof reasons.</p> <p>Resident# 24: Resident #24 has multiple Dx including ESRDrequiring dialysis 3x weekly, Diabetes, Hypertension and has also had bilateralamputations of lower extremities over the past year. Resident has hadmultiple hospitalizations and readmissions related to his decline in health.Lexapro was not a new medication to be started for resident. He had receivedthis on multiple occasions since his original admission date of 11-11-14. Therewere two occasions that resident was at hospital for his amputations. Duringreadmission to facility the surgeon omitted the Lexapro. Once back in facilityand seen by primary physician who has been following his care since hisadmission, the medication was restarted. Based upon his history ofpast amputations and other medical concerns resident has been faced with asdescribed by wife, the antidepressant was prescribed. Also, based upon direct observations such asdecline in appetite, resident refusals, non interest in socialization anddecreased desire to complete therapy it is very likely this resulted</p>		

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	<p>was discharged to the hospital all of his medications were discontinued. Then the doctor would restart medications that were needed when the resident was readmitted to the facility. She indicated there had been 2 times the Lexapro was restarted at the request of Resident #24's wife. The SSD indicated that the wife would indicate to her that Resident # 24 "is not himself" and that she wanted him restarted on the Lexapro. The SSD would then put in the request and the Nurse Practitioner looked at the request and restarted the Lexapro. The SSD indicated that the resident did not have any mood or behavior tracking. She indicated the Lexapro was stopped when he left the facility to have a below the knee amputation and was not restarted until the wife visited and requested it.</p> <p>During an interview with the DON on 01/06/2016 at 2:44 p.m., he indicated that Resident #24 was taking the Lexapro because he had always been on it.</p> <p>During an interview with the wife of Resident #24 on 01/07/2016 at 11:16 a.m., she indicated that Resident #24 had started taking Lexapro after the loss of his first leg. She indicated that it was either after the resident had his foot removed or after he broke his hip and he was readmitted to Miller's that he was</p>		<p>from situational depression r/t his health conditions. Primary physician has reviewed resident medication regimen. At this time feels resident is at his highest well being and is experiencing no ill effects. He feels it would be detrimental to his well being to make any changes at this time. The facility will continue to monitor for changes in mood and document these changes in the EMR. Will follow in monthly behavior meeting for possibility of future reduction. Resident's plan of care has been updated and new Behavior/Psychotropic Quarterly Medication Review will be completed by SW.</p> <p>All residents who are prescribed anti-depressant medication are at risk to be affected. All residents receiving anti-depressant medication will be reviewed to ensure that documentation and on-going monitoring is in place to support the need for the medication.</p> <p>Staff will be re-educated on the policy for use of psychoactive meds and the required documentation to be completed on 1-22-16. Additional training has been provided for the SW from the Regional Social Services Consultant regarding documentation guidelines and the P/P for psych medication monitoring.</p>	

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	<p>having times of delusion and having problems with seeing things. She indicated that she spoke to the DON about these behaviors and requested the Lexapro be restarted. She indicated that Resident #24 really needed the Lexapro because he was too much to handle without it.</p> <p>During an interview with the DON on 01/07/2016 at 11:57 a.m., he indicated the facility did not have any mood or behavior documentation or any paperwork to support Resident #24 being on Lexapro.</p> <p>During an interview with the SSD on 01/08/2016 at 2:45 p.m., she indicated Resident #24 was taking Lexapro for anxiety not depression. She indicated she must have mistakenly hit the wrong button and selected depression instead of anxiety when filling out paperwork.</p> <p>01/06/2016 at 12:30 p.m., a review of the facility behavior/ psychotropic med quarterly review, dated 11/17/2015, indicated the resident was taking Lexapro 10 mg 1 time daily for anxiety. Medication was started prior to readmission, d/c when resident went out to hospital and restarted upon wife's request.</p>		<p>TheQA Audit Tool "Behavior/Antipsychotic Medication Review " (Attachment D) will be completed by the DON/Designee weekly for eight weeks for any new psychoactive medication ordered, then monthly x3 months, and quarterly thereafter looking at all psychoactive medications in use. Any issues noted will be addressed immediately and logged on the "Quality Improvement Summary Log" (Attachment B). The summary log will be reviewed and changes will be made as needed in the monthly Quality Improvement meeting until issue is deemed resolved by the QA Committee.</p> <p>Date of Compliance: 2-7-16</p>	

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	<p>On 01/06/2016 at 12:36 p.m., a review of the social service assessment, dated 11/17/15, indicated Resident #24 was cognitively intact. It indicated the resident continued to participate in daily ADL's, that he was able to do and was more accepting of dialysis then the prior stay. The resident was on Lexapro 10 mg for anxiety 1 time per day.</p> <p>A review of the Psychotropic Medication Policy, dated 2/04/2008, was provided by the DON on 1/6/2016 at 3:40 p.m. It indicated "...Purpose... each resident receives only those medications, in doses and for the duration clinically indicated to treat the residents assessed condition(s)... ongoing monitoring will be in place to assess risks vs. benefits of continued medication use....Antidepressant use for depression such as... anxiety disorder...would put the drug in the psychopharmacological class resulting in the need for gradual dose reductions and behavioral monitoring...."</p> <p>A review of the Admit/Discharge To/ From Report provided by the administrator on 01/7/2015 at 2:09 p.m. indicated Resident #24 was admitted to the facility on 3/24/2015. He was discharged to the hospital on 7/20/2015 and readmitted to the facility on 7/28/2015. Resident #24 was then</p>			

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	<p>discharged to the back to the hospital on 11/2/105 and returned on 11/9/2015.</p> <p>A review of the current physician orders for Resident #24 provided by the Nurse Consultant on 1/7/2016 at 2:18 p.m., indicated Resident #24 was ordered to take Lexapro 10 mg beginning on 11/12/2015.</p> <p>A review of the physician orders provided by the Nurse Consultant on 1/7/2016 at 2:18 p.m., indicated a physician order dated 4/3/2015 indicating to restart Lexapro at 10 mg, a physician order dated 9/15/2015 indicated to increase the Lexapro to 15 mg, a physician order dated 11/11/2015 indicated to restart the Lexapro at 10mg and re-evaluate in 1 month.</p> <p>A review of the care plan titled "DEPRESSION" for Resident #24 provided by the Nurse Consultant on 1/7/2016 at 2:18 p.m., indicated the goals included "...Resident will exhibit no s/s [signs / symptoms] of mood decline" dated 4/30/2015.</p> <p>The "Facility- Behavior/ Psychotropic Med Quarterly Review" dated 11/17/2015 was provided by the Nurse Consultant on 1/7/2016 at 2:18 p.m., indicated "...F. Antidepressant</p>			

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	<p>Medications (Used for the treatment of depression only) Antidepressants for depression only- No behavior tracker required if used for depression document effectiveness with initiation, and dosage changes." The document further indicated Resident #24 was taking Lexapro daily for anxiety and the medication had been started prior to readmission, discontinued when resident went out to the hospital and restarted upon return to the facility at the wife's request. The target symptom listed was sleep disturbance.</p> <p>A review of the PHQ9's [Patient Health Questionnaire] provided by the Nurse Consultant on 1/7/2016 at 2:18 p.m., indicated on 8/23/2015, 9/18/2015, 10/28/2015, 11/16/2015, 11/21/2015 and 11/22/2015 indicated a score of zero with 1-4 being of minimal concern. The questions asked included but were not limited to "...over the last two weeks, have you been bothered by any of the following problems?...feeling down, depressed or hopeless, trouble falling or staying asleep..."</p> <p>A review of the physician progress notes provided by the DON began on 1/08/2015 at 10:32 a.m., and indicated the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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(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>1. The progress note, dated 3/25/2015, indicated Resident #24 was seen by MD who noted the resident had some confusion and possibly some delirium...The MD then noted that Resident #24 did not need any psychotropic medication.</p> <p>2. The progress note, dated 8/4/2015, indicated Resident #24 was seen by the Nurse Practitioner who noted the resident to be pleasant and cooperative.</p> <p>3. The progress note, dated 9/15/2015, indicated the resident was seen by the Nurse Practitioner with the chief complaint listed as "acute visit for wounds". The document further indicated the Nurse Practitioner noted the Resident #24 to be "pleasant and cooperative".</p> <p>3.1-48(a)(4)</p>			