

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|                        |   |        |   |  |
|------------------------|---|--------|---|--|
| F 0000<br><br>Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00181929.</p> <p>Complaint IN00181929 - Substantiated. Federal/State deficiencies related to allegations are cited at F282 and F309.</p> <p>Survey date: September 15 and 16, 2015</p> <p>Facility number: 000006<br/>Provider number: 155006<br/>AIM number: 100290220</p> <p>Census bed type:<br/>SNF/NF: 67<br/>Total: 67</p> <p>Census payor type:<br/>Medicare: 6<br/>Medicaid: 51<br/>Other: 10<br/>Total: 67</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on September 16, 2015.</p> | F 0000 | Please accept this plan of correction as credible allegation of compliance for the deficiencies cited during our complaint survey conducted on September 16, 2015 at Miller's Merry Manor Wabash East Facility. |  |
|------------------------|---|--------|---|--|

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
|--|---|--|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992 |
|--|--|

| (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 |
|----------------------------|--|---------------|---|----------------------|
| F 0282<br>SS=D<br>Bldg. 00 | <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a care plan was followed as written for 1 of 4 residents whose care plans were reviewed. (Resident B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident B was reviewed on 9/15/15 at 11:12 a.m. Diagnoses for Resident B included, but were not limited to, joint replacement, osteoarthritis, hypertension, diabetes mellitus and coronary artery disease.</p> <p>Review of hospital post discharge orders, dated 9/3/15, indicated for Thrombo Embolic Deterrent (TED) hose to be removed at night and for an Ace wrap to be applied to the left leg in the morning. The wrap was to be applied from Resident B's toes up to her thigh. The wrap was to be removed every morning and the TED hose were to be applied.</p> | F 0282        | <p>It is the policy of Miller's Merry Manor, Wabash East, that all services provided or arranged by the facility will be provided by qualified persons in accordance with each residents written plan of care.</p> <p>Resident B had no negative clinical outcomes related to this issue. She no longer resides in the facility.</p> <p>All residents have the potential to be affected. The facility will review all residents with treatment orders to ensure accuracy of order and proper administration of treatment is being completed by 9/29/15</p> <p>All licensed nurses will be re-educated on care plans, following physician orders, and order transcription on 9/28/15</p> <p>To ensure this deficient practice does not recur the DON/Designee will complete the QA Audit Tool "Treatment Orders/Care Plan Review" (Attachment A) on all residents receiving new or changed</p> | 10/16/2015           |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
|--|---|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992 |
|--|--|

| (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>Review of the September Treatment Administration Record (TAR), both September 5th and 6th, had initials with a circle around them, indicating the treatment had not been done.</p> <p>During an interview on 9/15/15 at 2:35 p.m., RN #1 indicated she read the order wrong. She indicated she did put the TED hose on in the morning, but did not wrap the leg at night on 9/5/15. She indicated on the morning of 9/6/15, she did observe the leg and initialed the date because she was going to call the Director of Nursing (DON) to clarify the order. She indicated the resident was discharged the same morning.</p> <p>Review of a current care plan, dated 9/3/15, indicated Resident B had a problem related to edema to the lower extremities. The interventions included, but were not limited to, "administer medication as ordered, assist to elevate legs, observe edema and notify physician."</p> <p>Another care plan problem, dated 9/3/15, indicated Resident B had a problem related to a potential risk for complications from an incision. Interventions included, but were not limited to, "administer treatment as ordered and notify physician of changes</p> |               | <p>treatment orders. Treatment Records will be reviewed to ensure treatment is administered as ordered. This tool will be completed daily x2 weeks, weekly x2 weeks, then monthly thereafter x 6 months</p> <p>Issues identified will be addressed immediately with the staff and education/guidance provided. All issues will be documented on the QA Summary Log (Attachment B )</p> <p>The QA Summary Log will be brought to QA monthly and reviewed and followed with the QA process.</p> <p>Date of Compliance- 10/16/15</p> |                      |

|  |   |   |   |                      |   |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992  |                      |   |
| (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 |   |
| F 0309<br>SS=D<br>Bldg. 00                               | <p>or indications that healing is impaired."</p> <p>This federal tag relates to Complaint IN00181929.</p> <p>3.1-35(g)(1)</p> <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders were accurately transcribed for 1 of 4 residents reviewed for physician orders. (Resident B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident B was reviewed on 9/15/15 at 11:12 a.m. Diagnoses for Resident B included, but were not limited to, joint replacement, osteoarthritis, hypertension, diabetes mellitus and coronary artery disease.</p> | F 0309  | <p>It is the policy of Miller's Merry Manor, Wabash East, 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. Resident B had no negative clinical outcomes related to this issue. She no longer resides in the facility. All residents have the potential to be affected by this deficient practice. The facility will review all residents with treatment orders to ensure accuracy of order and proper administration of treatment is being completed by 9/29/15.</p> | 10/16/2015           |   |

|  |   |   |  |                      |   |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992   |                      |   |
| (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>During review of the hospital post discharge orders, dated 9/3/15, an order for ice therapy was noted. The order indicated for ice to be applied to the left knee after therapies and as needed.</p> <p>Review of the admission Medication Review Report, dated 9/3/15, indicated an initial order that stated "may apply ice packs to left knee after therapies and as needed for pain/swelling." The order was signed by the physician on 9/11/15.</p> <p>A clarification telephone order form, dated 9/6/15 at 7:07 a.m., indicated to "Apply ice pack to left knee after therapies and PRN [as needed] for pain/swelling."</p> <p>Review of the September Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated ice was only applied one time during the day shift on 9/4/15. Resident B refused ice on 9/5/15 and 9/6/15.</p> <p>During an interview on 9/15/15 at 12:20 p.m., RN #2 indicated she put the initial orders into the computer. She indicated she could have put the orders in for the day shift to apply ice since she was receiving therapy during the day. She indicated she should have clarified the orders better. She stated that the word</p> |   | <p>The facility will re-educate all licensed staff on care plans, following physician orders, and order transcription on 9/28/15. To ensure this does not reoccur the DON/Designee will complete the QA tool "Treatment Orders/Care Plan Review" (Attachment A) on all residents receiving new or changed treatment orders. Treatment Records will be reviewed to ensure treatment is administered as ordered. This tool will be completed daily x2 weeks, weekly x2 weeks, then monthly thereafter x 6 months. Issues identified will be addressed immediately with the staff and education/guidance provided. All issues will be documented on the QA Summary Log (Attachment B ) The QA Summary Log will be brought to QA monthly and reviewed and followed with the QA process. Date of Compliance- 10/16/15</p> |                      |   |

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992 |  |   |  |
| (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>"may" indicated the resident would have to request ice, rather than a routine order.</p> <p>Review of a current care plan, dated 9/3/15, indicated Resident B had a problem related to edema to the lower extremities. The interventions included, but were not limited to, "administer medication as ordered, assist to elevate legs, observe edema and notify physician.</p> <p>Another care plan problem, dated 9/3/15, indicated Resident B had a potential risk for complications from an incision. Interventions included, but were not limited to, "administer treatment as ordered and notify physician of changes or indications that healing is impaired."</p> <p>Review of a current facility policy, dated 6/15/10, titled "Physician Order Transcription Procedure", which was provided by the Director of Nursing on 9/16/15 at 11:45 a.m., indicated the following:<br/>"POLICY:<br/>A. It is the policy of Miller's Merry Manor to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration.<br/>...E. All orders will be dated upon receipt, and will include the medication,</p> |   |   |  |  |   |  |

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155006 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>09/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MILLER'S MERRY MANOR |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1900 N ALBER ST<br>WABASH, IN 46992                                    |                      |   |
| (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 |   |
|  | dose, amount, route of administration and frequency of administration.<br>This federal tag relates to Complaint IN00181929.<br><br>3.1-37(a) |   |   |                      |   |