

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 01/16/2015
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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 the Investigation of Complaint #IN00162301.</p> <p>Complaint #IN00162301- Substantiated. Federal/State deficiencies related the allegations are cited at F250 and F323.</p> <p>Survey dates: January 14,15 & 16, 2015</p> <p>Facility number: 000505 Provider number: 155556 AIM number: 100266350</p> <p>Survey team: Michelle Carter, RN- TC</p> <p>Census bed type: SNF: 16 SNF/NF: 96 Total: 112</p> <p>Census payor type: Medicare: 9 Medicaid: 73 Other: 30 Total: 112</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by</p>	F000000	<p>Mrs. Tammy Alley, Please accept the following Plan Of Correction as credible allegation of compliance to the deficiencies cited here during a survey conducted on January 16, 2015. If you have any questions or need further information, please do not hesitate to contact me here at the facility at 765-675-8791. Respectfully, 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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F000250 SS=G	<p>Tammy Alley RN on January 22, 2015.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure appropriate follow up communication was completed in order to provide appropriate transfer and placement for a resident with physical aggressive behaviors and to attain and maintain the safety of the other residents, resulting in a terminal injury for a fellow resident (Resident B), for 1 of 3 residents reviewed for physical behaviors, in a sample of 6. (Resident C)</p> <p>Findings include:</p> <p>The record for Resident C was reviewed on 1/14/15. Diagnoses for Resident C included, but were not limited to, Alzheimer's disease, anxiety disorder, and delusional disorder.</p> <p>Nursing notes, dated 7/16/14 at 9:37 p.m., indicated Resident C hit another resident (Resident D) and swatted at kitchen staff. Family was notified of the altercation and stated Resident C did have a "mean streak" and had acted this</p>	F000250	<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 free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident C was transferred out of the facility and relocated to another LTC facility. There are currently no residents exhibiting physically aggressive behavior at this time. All Nurses and Social Service Staff were in-serviced on the Behavior Assessment & Management Policy (attachment A). Social Service began using the Social Service Pertinent Charting Form (attachment B) on 1/28/15 and will be using it on a daily basis to ensure timely and adequate follow up. The Behavior Management QA Tool (Attachment C) will be completed by SS or designee daily for 2 weeks, then weekly for 4 weeks, then monthly thereafter. Any issues will be corrected immediately, recorded on a</p>	01/30/2015			

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	<p>way, at home, towards family, including Resident C's husband.</p> <p>Nursing notes indicated Resident C continued to demonstrate physical agitation and aggression toward others, intermittently, through July, August, September, and October 2014. For evaluation and treatment, Resident C was placed at a geriatric psychological facility from 10/14/14 to 10/22/14.</p> <p>After the return from the geriatric psychological facility, Resident C's agitation and physical aggression toward others continued. Nursing notes indicated the following:</p> <p>10/23/14- Resident C punched another resident on the back, leaving a 7 x 9 centimeter (cm) red area on the other resident's back.</p> <p>10/26/14- Resident C punched another resident, twice, on the arm, and tried to take away the other resident's jacket.</p> <p>10/29/14- Resident C pushed a nurse, during care.</p> <p>Social Services notes, dated 10/30/14, indicated Resident C's power of attorney (POA) agreed to the transfer of Resident C to a behavioral facility.</p> <p>Documentation did not indicate further correspondence was completed related to</p>		<p>facility QA tracking log and reviewed in the facility QA meeting monthly with any new recommendations implemented. These corrective action will be completed by 1/30/15. Miller's Merry Manor of Tipton is requesting a paper review IDR of F-323 & F-250. Through this process we request that the tags be deleted completely. The facility had in place an effective Social Service developed plan of care to manage Resident C's behaviors. Of the 98 episodes of physical behavior and 73 episodes of mood related behavior documented in November & December 2014, only 10 times was the care planned interventions not effective. This leaves 161 times that the interventions put in place by the Social Service Director were effective. Please refer to the Documentation Survey Reports for November & December, 2014 (attachments 1-14, including the legend). Please also see the Medication Administration Records (attachment 15 & 16) for November & December 2014 indicating the use of as-needed Tylenol orders when pain was identified as well as attachment 17 which shows the administration of a new order for routine Trazodone that started on 12/29/14. The Social Service Director is the Director of the Memory Care Unit and makes at</p>		

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	<p>the transfer.</p> <p>During an interview on 1/16/15 at 10:45 a.m., the Social Services Director (SSD) indicated she spoke with Resident C's POA regarding a more appropriate facility placement for Resident C. The POA agreed to the transfer. The SSD indicated referral calls were not made. Staff told the SSD Resident C was doing better, and the management team decided to give Resident C another chance.</p> <p>Behavior monitoring logs for November 2014 indicated Resident C had 42 episodes related to mood behavior: anger at staff, intrusive episodes with peers and 51 episodes related to physical behavior: hitting staff during care.</p> <p>The behavior monitoring log for December 1 - 29, 2014 indicated Resident C had 31 episodes related to mood behavior: anger at staff, intrusive episodes with peers and 47 episodes related to physical behavior: hitting staff during care.</p> <p>Nursing notes, dated 12/30/14 at 11:20 a.m., indicated Resident C physically pushed Resident B to the floor.</p> <p>Resident B complained of leg pain and was transferred to the emergency room.</p>		<p>least daily visits on the unit to monitor & interact with those residents. She also attends and is highly involved in routine meetings where behaviors are discussed such as, Morning meeting, Behavior Management Meetings and Health Care Conferences which all include the Interdisciplinary Team. In conclusion we feel that there was an appropriate plan of care in place with interventions that were effective to manage this resident's behaviors as well as Social Service involvement. We ask that you take this into consideration and delete these tags.</p>				

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F000323 SS=G	<p>Hospital x-ray results, dated 12/30/14, indicated a spiral fracture of the right femoral shaft with 100% posterior and medial displacement. Hospital physician notes, dated 12/31/14, indicated Resident B was suffering a CHF (congestive heart failure) exacerbation as a result of the stressor of fall/fracture. Resident B was not a surgery candidate and palliative care was put in place. Resident B expired 1/10/15.</p> <p>This federal tag relates to Complaint #IN00162301.</p> <p>3.1-34(a)</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 record review and interview, the facility failed to provide adequate supervision and intervention to protect residents from a resident with known aggressive physical behaviors toward others, resulting in terminal injury, for 2 of 3 residents reviewed for accidents, in a sample of 6. (Resident B and C)</p> <p>Findings include:</p>	F000323	<p>F-250 Provision of medically related social services. It is the policy of Miller's Merry Manor to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident C was transferred out of the facility and relocated to another LTC facility. There are currently no residents exhibiting physically aggressive behavior at</p>	01/30/2015			

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	<p>1. The clinical record for Resident B was reviewed on 1/15/14. Diagnoses for Resident B included but were not limited to, dementia without behavioral disturbances, generalized muscle weakness, osteoporosis, kyphosis, high blood pressure, and congestive heart failure.</p> <p>Nursing fall risk assessment indicated the following: Date and time of occurrence: 12/30/14 at 11:20 a.m. Summary of occurrence: Resident B was pushed to the floor by another resident (Resident C). Injury: Unknown at this time. Root cause of fall: agitated resident. Resident B was sent to the hospital for evaluation and treatment.</p> <p>Hospital documentation and Trauma Progress Note, dated 1/3/15 and titled Final Report, indicated a "displaced spiral right femur fracture secondary to fall, was pushed (from standing) by another resident at nursing home. Patient is not a surgical candidate at this time. We can minimally optimize patient by treating acute CHF exacerbation exacerbated by stressor of fall/fracture...."</p> <p>A hospital Palliative Care Initial Consult Note, dated 12/31/14, indicated "...this</p>		<p>this time. All Nurses and Social Service Staff were in-serviced on the Behavior Assessment & Management Policy (attachment A). Social Service began using the Social Service Pertinent Charting Form (attachment B) on 1/28/15 and will be using it on a daily basis to ensure timely and adequate follow up. The Behavior Management QA Tool (Attachment C) will be completed by SS or designee daily for 2 weeks, then weekly for 4 weeks, then monthly 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 1/30/15. Miller's Merry Manor of Tipton is requesting a paper review IDR of F-323 & F-250. Through this process we request that the tags be deleted completely. The facility had in place an effective Social Service developed plan of care to manage Resident C's behaviors. Of the 98 episodes of physical behavior and 73 episodes of mood related behavior documented in November & December 2014, only 10 times was the care planned interventions not effective. This leaves 161 times that the interventions put in place by the Social Service Director were effective. Please refer to</p>		

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	<p>injury was likely a terminal event for the patient"</p> <p>Facility nursing notes indicated Resident B returned on 1/3/15. Orders for comfort measures only.</p> <p>Facility nursing notes indicated Resident B expired on 1/10/15.</p> <p>2. The record for Resident C was reviewed on 1/14/15. Diagnoses for Resident C included, but were not limited to, Alzheimer's disease, anxiety disorder, and delusional disorder.</p> <p>Nursing notes, dated 7/16/14 at 9:37 p.m., indicated Resident C hit another resident (Resident D) and swatted at kitchen staff. Family was notified of the altercation and stated Resident C did have a "mean streak" and had acted this way, at home, towards family, including Resident C's husband.</p> <p>Nursing notes indicated Resident C continued to demonstrate physical agitation and aggression toward others, intermittently, through July, August, September, and October 2014. For evaluation and treatment, Resident C was placed at a geriatric psychological facility from 10/14/14 to 10/22/14.</p>		<p>the Documentation Survey Reports for November & December, 2014 (attachments 1-14, including the legend). Please also see the Medication Administration Records (attachment 15 & 16) for November & December 2014 indicating the use of as-needed Tylenol orders when pain was identified as well as attachment 17 which shows the administration of a new order for routine Trazodone that started on 12/29/14. The Social Service Director is the Director of the Memory Care Unit and makes at least daily visits on the unit to monitor & interact with those residents. She also attends and is highly involved in routine meetings where behaviors are discussed such as, Morning meeting, Behavior Management Meetings and Health Care Conferences which all include the Interdisciplinary Team. In conclusion we feel that there was an appropriate plan of care in place with interventions that were effective to manage this resident's behaviors as well as Social Service involvement. We ask that you take this into consideration and delete these tags.</p>				

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	<p>After the return from the geriatric psychological facility, Resident C's agitation and physical aggression toward others continued. Nursing notes indicated the following:</p> <p>10/23/14- Resident C punched another resident on the back, leaving a 7 x 9 cm. red area on the other resident's back.</p> <p>10/26/14- Resident C punched another resident, twice, on the arm, and tried to take away the other resident's jacket.</p> <p>10/29/14- Resident C pushed a nurse, during care.</p> <p>Social Services notes, dated 10/30/14, indicated Resident C's power of attorney (POA) agreed to the transfer of Resident C to a behavioral facility.</p> <p>Documentation did not indicate further correspondence was completed related to the transfer.</p> <p>During an interview on 1/16/15 at 10:45 a.m., the Social Services Director (SSD) indicated she spoke with Resident C's POA regarding a more appropriate facility placement for Resident C. The POA agreed to the transfer. The SSD indicated referral calls were not made. Staff told the SSD Resident C was doing better, and the management team decided to give Resident C another chance.</p>			

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	<p>Behavior monitoring logs for November 2014 indicated Resident C had 42 episodes related to mood behavior: anger at staff, intrusive episodes with peers and 51 episodes related to physical behavior: hitting staff during care.</p> <p>The behavior monitoring log for December 1 - 29, 2014 indicated Resident C had 31 episodes related to mood behavior: anger at staff, intrusive episodes with peers and 47 episodes related to physical behavior: hitting staff during care.</p> <p>Nursing notes indicated the following: 12/25/14 at 10:52 p.m.- "Resident refused care, was combative and yelling during toileting" 12/28/14 at 3:55 p.m.- "Resident very combative during toileting, required 2-assist. Resident kicking, smacking and pushing.... Resident still seemed agitated after toileting in hallways towards people walking by. Nurse offered food/drinks, resident did not accept." 12/29/14 at 11:06 a.m., indicated Resident C "swung her fist at dietary staff member while they were putting tablecloths on tables. Has had occasional episodes of crying and agitation so far today."</p> <p>A nursing document titled incident</p>						

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	<p>investigation, indicated on 12/30/14 at 11:20 a.m., Resident B was pushed to the floor by Resident C. The incident investigation indicated previously planned interventions were not in place at the time of the event (fall). "Staff unable to do interventions due to agitation. 1:1 (one one one supervision) provided until transport arrived."</p> <p>During an interview on 1/15/15 at 3:45 p.m., the SSD indicated staff were aware of Resident C's agitation and physical aggressive behaviors, since her admission.</p> <p>CNA #1 indicated awareness of Resident C's agitation and aggressive behaviors toward others, during an interview on 1/16/15 at 9:30 a.m. CNA #1 indicated when Resident C displayed agitated behaviors, staff were expected to provide one on one supervision, if enough staff were available. Resident C showed agitation and aggression, frequently, and the behaviors were unpredictable. CNA #1 explained staff did not know what triggered the aggression and/or agitation. There was no way to tell if a combative moment was coming. She (Resident C) acted this way toward staff and residents, equally. Resident C did not single out one person.</p>				

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	<p>CNA #1 explained the following, as she recalled the morning of 12/30/14. The unit was staffed with a nurse, CNA #1, and a CNA orientee. This was the CNA orientee's first day. Resident C was very aggressive, that day. The unit staff did not call any other staff for assistance, that morning, because three people (staff) were on the unit, including the orientee. Despite unfamiliarity with the residents, the orientee was supposed to be able to help to allow CNA #1 to provide one on one supervision, if needed. Due to Resident C's increased agitation and combativeness, two staff (CNA #1 & the nurse) were required to assist her (Resident C) with toileting. After Resident C was toileted, the nurse and CNA #1 left her room. Resident C was still agitated, at that time. CNA #1 was walking on the unit, with another resident and the nurse was approaching Resident B to provide care. Resident B was standing with her walker, against the wall, outside her (Resident B) room. Resident C exited her room, walked very fast, and pushed Resident B, hard, to the floor, unexpectedly. Resident C continued to be aggressive.</p> <p>This federal tag relates to Complaint #IN00162301.</p> <p>3.1-45(a)(2)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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