STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155557	A. BUILDING 00 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1651 N CAMPBELL ST INDIANAPOLIS, IN46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of Complaint IN00100306. Complaint IN00100306: Substantiated. Federal deficiencies related to the allegation are cited at F157 and F282. Survey dates: December 19 and 20, 2011 Facility number: 000500 Provider number: 155557 AIM number: 100266220 Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Heather Lay, R.N. Census bed type: SNF--17 SNF/NF--44 Total--61 Census payor type: Medicare--20 Medicaid--35 Other--6 Total--61 Sample: 6	F0000	We respectfully request paper compliance for this plan of correction. The resident cited (Resident #D) no longer resides in the facility. The nurse responsible for not notifying the MD/NP is no longer employed at the faciltiy. There are no other residents found to be affected by this. The facility will diligently follow the corrective measure put into place to ensure continued compliance.Respectfully submitted,Matthew D. shafer, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 12/22/11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the	F0157	We respectfully request paper	01/09/2012

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	facility failed to notify and consult with the attending physician and/or Nurse Practitioner about the need to evaluate a resident for any condition changes, as previously ordered by the Nurse Practitioner, to determine if there was a need to continue or alter treatment following a 4-day course of antipsychotic medications; for 1 of 6 residents reviewed who were receiving antipsychotic medications, in a sample of 6 residents reviewed. [Resident #D] Findings include: Following the entrance conference on 12/19/11 at 10:15 A.M., the Administrator provided a list of resident admissions and discharges for the months of October, November, and December, 2011. From the list, Resident #D was identified as having multiple admissions and discharges through all 3 months. The closed clinical record was reviewed on 12/19/11 at 11:35 A.M. The resident was initially admitted to the facility from an acute care hospital on 10/10/11. The hospital discharge summary, dated 10/7/11, listed a primary diagnosis of venous stasis ulcers and lower extremity cellulitis. Other discharge diagnoses were listed as: lower extremity edema, chronic		compliance for this plan of correction. The resident cited (Resident #D) no longer resides in the facility. The nurse responsible for not notifying the MD/NP is no longer employed at the facility. There were no other residents found to be affected by this. The facility will diligently follow the corrective measure put into place to ensure compliance. F157-D 1.) Resident D was discharged to home and no longer resides in the facility. The nurse responsible for not following the plan of care or notifying the MD/NP is no longer employed @ the facility. The DON was made aware of the fact that the the seroquel was stopped and the MD/NP was not notified on 11-16-11. This was investigated and corrected as soon as it was known. The Nurse responsible resigned at the time. A medication error was completed which included the fact that the MD/NP were not notified appropriately. 2.) All residents have the potential to be affected by this practice. All current residents' physicians' orders have been audited for any timed orders, orders to re-evaluate and notify MD/NP or any other needed clarifications or follow up that may be needed. There were no other residents found to be affected. 3.) All licensed nurses will be in-serviced on the importance of closely evaluating and monitoring	

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	renal failure, diabetes mellitus--type 2, hypothyroidism, hyperlipidemia, anemia, anticoagulation, incontinence, and asthma. Discharge medications included, but were not limited to, antibiotics, pain and blood pressure medications, and anticoagulants. There were no orders for any psychotropic medications. An "Initial Assessment," completed by the facility's consultant psychiatric APRN [Advanced Practice Registered Nurse] indicated the resident had additional diagnoses of bipolar disease and a history of self-mutilation/self-harm ("razor blades") with the last episode in 2006. A subsequent evaluation, completed on 10/24/11, indicated "... she showed Social Service her arms and stated 'I used to be a cutter... I'm bipolar.' She came for with no psych [psychiatric] diagnoses, no psych meds on home or hospital list...." Effexor [an antidepressant medication] and Risperdal [an antipsychotic medication] were ordered following the evaluation on 10/24/11. On 11/3/11, the time not indicated, the Nurse Practitioner wrote the following order: "1. D/C [discontinue] Risperdal 2. Give Effexor every other day times 7 days then D/C.		all medication orders with special attention to timed medication orders, antipsychotic or other tapered medications, and admission/re-admission orders including the need to notify the MD/NP for clarification and/or follow up. In addition to this in-service this is a part of all new nurse orientation. Re-education will be completed twice annually for current nurses and as needed if any concerns are identified. This education will include completely following the residents' plan of care including but not limited to physicians orders. In-service will be held on 1-6-11. 4.) All current residents' medication orders have been audited for timed medication and appropriate MD/NP notification by DON/ADON. All resident admission/re-admission orders will be written by a licensed nurse and double checked by a second license nurse with-in the first 8 hours. This will be noted by co-signature on all orders. All orders will also be verified with MD/NP at the time, requesting clarification of any unclear or missing orders. All medication/ancillary orders are inputted into the electronic medical record by a licensed nurse. The licensed nurse will audit all orders for any timed, tapered medications or conditions that need to be followed up on or	

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	3. Seroquel [an antipsychotic medication]: 50 mg. day 1 at H.S. [bedtime]; 100 mg. p.o. [by mouth] on Day 2; 200 mg. p.o. on day 3; 300 mg. on day 4." There were no additional instructions on continuing the medication following the fourth day. The November, 2011 M.A.R. indicated the resident was to have received the first dose of Seroquel 50 mg. at 8:00 P.M. on 11/4/11. However, a "Progress Notes" entry on 11/4/11 at 2:12 P.M. indicated the resident was transferred to the acute care hospital E.R. at 1:45 P.M. for a complaint of abdominal pain. The resident returned to the facility on 11/5/11. A facility "Physician's Telephone Order," dated 11/5/11 at 6:30 P.M. and co-signed by the Nurse Practitioner on 11/5/11, indicated: "Clarification: Seroquel 50 mg. tablet 1 p.o. at H.S. day 1 times 1 on 11/5/11; then Seroquel 100 mg. 1 p.o. at H.S. day 2 times 1 on 11/6/11; then Seroquel 200 mg. tablet 1 p.o. at H.S. day 3 times 1 on 11/7/11; the Seroquel 300 mg. tablet 1 p.o. at H.S. day 4 times 1 on 11/8/11; then M.D. [Medical Doctor] to evaluate for any change or new orders on 11/8/11." The November, 2011 M.A.R. indicated		monitored closely on a tracking tool. (See attached tool titled Mar's and Tar's) This will then be followed up on by Unit Managers or designee to ensure accuracy and compliance. A 72 hour chart audit is also completed by the Medical Records Designee and will note any areas that need MD/NP notification or clarification and inform the appropriate nurse of needed follow up. The consultant pharmacist will also pay particularly close attention to timed orders and tapered medications as those audits are conducted on a monthly basis. A weekly medication administration audits will be completed to ensure on-going compliance. All of the above audits will be done on an on-going basis unless recommended by the Quality Assurance Committee or Medical Director to do otherwise. As always and per policy any error discovered will be addressed and corrected immediately, and staff responsible will be re-educated and counseled accordingly. The DON or Designee will be responsible for all of the above. 5.) Date of Completion___1-9-11_____	

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	the resident received the Seroquel 50 mg. on 11/5 at 8:00 P.M., the 100 mg. on 11/6 at 8:00 P.M., the 200 mg. on 11/7 at 8:00 P.M., and the 300 mg. on 11/8 at 8:00 P.M. The resident did not receive any further doses of the Seroquel until 11/16/11 at 9:00 P.M. A Nurse Practitioner progress note, dated 11/16/11 at 3:55 P.M., indicated :"I received a call from the staff stating patient was having significant behavior issues and they found she had inadvertently been stopped on her psych drug on 11/8. I asked the staff to trouble shoot the cause and restarted Seroquel as 100 mg. X 3 days, 200 mg. X 3 days, then 300 mg. q.d. [every day] thereafter...." A "Progress Notes" entry, dated 11/10/11 at 6:50 P.M. and prior to the restart of the Seroquel medication on 11/16/11, indicated "At 6:50 P.M. Indianapolis Metro Police arrived to facility to respond to call that was placed by client. Metro Police officer stated to this writer that call was received per resident stating that she had plans to kill herself. M.D. on call notified and new order received for: 1.) Send to E.R. hospital for emergency psychiatric evaluation for Dx. [diagnosis] suicidal risk, plan, and means to carry			

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	out...." The resident was transported out of the facility by ambulance to an acute care hospital at 7:10 P.M. The resident returned to the facility on 11/11/11 at 7:48 A.M. with orders to follow-up with psychiatric services. The resident was placed on every 30 minute suicide watch checks until seen by the consultant psychiatric APRN on 11/11/11 at 1:45 P.M. Progress notes from the APRN on 11/11/11 indicated the resident was no longer suicidal--"Patient was angry with friends, family yesterday, then regretted her angry outburst and then 'as always want to hurt myself.' Denies desire for self harm now. Denies suicidal ideation now...." The every 30 minute suicide watch checks were discontinued on 11/11/11 at 11:30 A.M., but a "Assessment for New Behavior--7 Day Observation Checklist" observation for "suicide ideation" was continued through 11/17/11, with no further indications from the resident of self-harm or suicidal thoughts. Electronic records between 11/9 and 11/16/11 indicated the attending physician and Nurse Practitioner had been contacted regarding a complaint of left wrist pain--for which an X-Ray was ordered, and for an evaluation for continued use of eye			

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	drops previously ordered for an eye infection. There was no evidence that nursing staff had notified or consulted with the physician or Nurse Practitioner about the previous order for the "M.D. [Medical Doctor] to evaluate for any change or new orders on 11/8/11" following the 4 day course of antipsychotic medication, in order to determine a further course of treatment. In an interview on 12/20/11 at 2:00 P.M., the Director of Nursing confirmed that Resident #D did not receive any Seroquel following the 300 mg. dose on 11/8 until the medication was re-instated on 11/16/11. She indicated she would not have expected a nurse on evening or night shift on 11/8/11 to call the physician or Nurse Practitioner related to the clarification order on 11/5 for "... M.D. to evaluate for any change or new orders...." However, a licensed nurse should have called the physician or Nurse Practitioner for a follow-up the next day, 11/9/11, but "no one considered calling the doctor." This Federal tag relates to Complaint IN00100306. 3.1-5(a)(3)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a Physician/Nurse Practitioner order for a follow-up evaluation was completed, related to the use of an antipsychotic medication after an initial 4-day titrated dose; for 1 of 6 residents reviewed who were receiving psychotropic medications, in a sample of 6 residents reviewed. [Resident #D] Findings include; Following the entrance conference on 12/19/11 at 10:15 A.M., the Administrator provided a list of resident admissions and discharges for the months of October, November, and December, 2011. From the list, Resident #D was identified as having multiple admissions and discharges through all 3 months. The closed clinical record was reviewed on 12/19/11 at 11:35 A.M. The resident was initially admitted to the facility from an acute care hospital on 10/10/11. The hospital discharge summary, dated 10/7/11, listed a primary diagnosis of venous stasis ulcers and lower extremity	F0282	F282 1.) Resident D was discharged to home and no longer resides in the facility. The nurse responsible for not following the plan of care or notifying the MD/NP is no longer employed @ the facility. The DON was made aware of the fact that the the seroquel was stopped and the MD/NP was not notified on 11-16-11. This was investigated and corrected as soon as it was known. The Nurse responsible resigned at the time. A medication error was completed which included the fact that the MD/NP were not notified appropriately. 2.) All residents have the potential to be affected by this practice. All current residents' physicians' orders have been audited for any timed orders, orders to re-evaluate and notify MD/NP or any other needed clarifications or follow up that may be needed. There were no other residents found to be affected. 3.) All licensed nurses will be in-serviced on the importance of closely evaluating and monitoring all medication orders with special attention to timed medication orders, antipsychotic or other tapered medications, and admission/re-admission orders including the need to notify the	01/09/2012

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	cellulitis. Other discharge diagnoses were listed as: lower extremity edema, chronic renal failure, diabetes mellitus--type 2, hypothyroidism, hyperlipidemia, anemia, anticoagulation, incontinence, and asthma. Discharge medications included, but were not limited to, antibiotics, pain and blood pressure medications, and anticoagulants. There were no orders for any psychotropic medications. An "Initial Assessment," completed by the facility's consultant psychiatric APRN [Advanced Practice Registered Nurse] indicated the resident had additional diagnoses of bipolar disease and a history of self-mutilation/self-harm ("razor blades") with the last episode in 2006. A subsequent evaluation, completed on 10/24/11, indicated "... she showed Social Service her arms and stated 'I used to be a cutter... I'm bipolar.' She came for with no psych [psychiatric] diagnoses, no psych meds on home or hospital list...." Effexor [an antidepressant medication] and Risperdal [an antipsychotic medication] were ordered following the evaluation on 10/24/11. The October, 2011 M.A.R. [Medication Administration Record] indicated the resident received the Risperdal 0.5 mg. [milligrams] daily at 8:00 P.M. on 10/24, 10/25, and 10/26/11. A "Progress Notes"		MD/NP for clarification and/or follow up. In addition to this in-service this is a part of all new nurse orientation. Re-education will be completed twice annually for current nurses and as needed if any concerns are identified. This education will include completely following the residents' plan of care including but not limited to physicians orders. In-service will be held on 1-6-11. 4.) All current residents' medication orders have been audited for timed medication and appropriate MD/NP notification by DON/ADON. All resident admission/re-admission orders will be written by a licensed nurse and double checked by a second license nurse with-in the first 8 hours. This will be noted by co-signature on all orders. All orders will also be verified with MD/NP at the time, requesting clarification of any unclear or missing orders. All medication/ancillary orders are inputted into the electronic medical record by a licensed nurse. The licensed nurse will audit all orders for any timed, tapered medications or conditions that need to be followed up on or monitored closely on a tracking tool. (See attached tool titled Resident Re-Evaluation) This will then be followed up on by Unit Managers or designee to ensure accuracy and compliance.	

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	entry on 10/27/11 at 10:20 A.M. indicated the resident had become unresponsive while in therapy and was subsequently sent, and admitted, to an acute care hospital. The resident returned to the facility on 11/2/11 with hospital orders for Risperdal 0.5 mg. twice daily. The November, 2011 M.A.R. indicated the resident did not receive a dose of the Risperdal at 9:00 P.M. on 11/2, but received a dose at 9:00 A.M. on 11/3/11. On 11/3/11, the time not indicated, the Nurse Practitioner wrote the following order: "1. D/C [discontinue] Risperdal 2. Give Effexor every other day times 7 days then D/C. 3. Seroquel [an antipsychotic medication]: 50 mg. day 1 at H.S. [bedtime]; 100 mg. p.o. [by mouth] on Day 2; 200 mg. p.o. on day 3; 300 mg. on day 4." There were no additional instructions on continuing the medication following the fourth day. The November, 2011 M.A.R. indicated the resident was to have received the first dose of Seroquel 50 mg. at 8:00 P.M. on 11/4/11. However, a "Progress Notes" entry on 11/4/11 at 1:27 P.M. indicated		A 72 hour chart audit is also completed by the Medical Records Designee and will note any areas that need MD/NP notification or clarification and inform the appropriate nurse of needed follow up. The consultant pharmacist will also pay particularly close attention to timed orders and tapered medications as those audits are conducted on a monthly basis. A weekly medication administration audits will be completed to ensure on-going compliance. All of the above audits will be done on an on-going basis unless recommended by the Quality Assurance Committee or Medical Director to do otherwise. As always and per policy any error discovered will be addressed and corrected immediately, and staff responsible will be re-educated and counseled accordingly. The DON or Designee will be responsible for all of the above. 5.) Date of Completion___1-9-11_____	

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	"Resident in room at this time requesting to go to the hospital. Writer went to room and assessed resident. Blood pressure 128/72, Pulse 80, Temperature 97.9, O2 [oxygen saturation] 98% with oxygen on at 2 Liters. Apical heart rate normal. Lungs clear to auscultation. Complained of side pain, offered her a pain pill and she accepted." A "Progress Notes's" entry at 1:50 P.M. indicated "Staff called resident's [family member] to inform her that N.P. [Nurse Practitioner, name] was notified of resident's condition and will not give order for transfer to E.R. [emergency room]. [Family member] states 'She is going to the hospital. I called 911 because she said she has stomach pain when she breathes in and you aren't doing anything for her.' Writer placed [family member] on hold and allowed A.D.O.N. [Assistant Director of Nursing] to speak with her. [Family member]continued to insist she go to E.R. Repaged N.P. and informed her of [family member's] insistence and new order received to send resident to E.R. with 911 at this time." The resident was transferred to the acute care hospital E.R. at 1:45 P.M. The resident returned to the facility on 11/5/11. A facility "Physician's Telephone Order," dated 11/5/11 at 5:00 P.M. and co-signed by the Nurse			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Practitioner on 11/5/11, included, but was not limited to the following orders: "D/C Effexor; D/C Risperdal due to sensitivity reaction." A facility "Physician's Telephone Order," dated 11/5/11 at 6:30 P.M. and co-signed by the Nurse Practitioner on 11/5/11, indicated: "Clarification: Seroquel 50 mg. tablet 1 p.o. at H.S. day 1 times 1 on 11/5/11; then Seroquel 100 mg. 1 p.o. at H.S. day 2 times 1 on 11/6/11; then Seroquel 200 mg. tablet 1 p.o. at H.S. day 3 times 1 on 11/7/11; the Seroquel 300 mg. tablet 1 p.o. at H.S. day 4 times 1 on 11/8/11; then M.D. [Medical Doctor] to evaluate for any change or new orders on 11/8/11." The November, 2011 M.A.R. indicated the resident received the Seroquel 50 mg. on 11/5 at 8:00 P.M., the 100 mg. on 11/6 at 8:00 P.M., the 200 mg. on 11/7 at 8:00 P.M., and the 300 mg. on 11/8 at 8:00 P.M. The resident did not receive any further doses of the Seroquel until 11/16/11 at 9:00 P.M. A Nurse Practitioner progress note, dated 11/16/11 at 3:55 P.M., indicated :"I received a call from the staff stating patient was having significant behavior			

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	155557	A. BUILDING 00 B. WING	12/20/2011

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	issues and they found she had inadvertently been stopped on her psych drug on 11/8. I asked the staff to trouble shoot the cause and restarted Seroquel as 100 mg. X 3 days, 200 mg. X 3 days, then 300 mg. q.d. [every day] thereafter...." A "Progress Notes" entry, dated 11/10/11 at 6:50 P.M. and prior to the restart of the Seroquel medication on 11/16/11, indicated "At 6:50 P.M. Indianapolis Metro Police arrived to facility to respond to call that was placed by client. Metro Police officer stated to this writer that call was received per resident stating that she had plans to kill herself. M.D. on call notified and new order received for: 1.) Send to E.R. hospital for emergency psychiatric evaluation for Dx. [diagnosis] suicidal risk, plan, and means to carry out...." The resident was transported out of the facility by ambulance to an acute care hospital at 7:10 P.M. The resident returned to the facility on 11/11/11 at 7:48 A.M. with orders to follow-up with psychiatric services. The resident was placed on every 30 minute suicide watch checks until seen by the consultant psychiatric APRN on 11/11/11 at 1:45 P.M. Progress notes from the APRN on 11/11/11 indicated the resident was no longer suicidal--"Patient was angry with			

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	friends, family yesterday, then regretted her angry outburst and then 'as always want to hurt myself.' Denies desire for self harm now. Denies suicidal ideation now...." The every 30 minute suicide watch checks were discontinued on 11/11/11 at 11:30 A.M., but a "Assessment for New Behavior--7 Day Observation Checklist" observation for "suicide ideation" was continued through 11/17/11, with no further indications from the resident of self-harm or suicidal thoughts. On 11/17/11, the resident had a scheduled admission to an acute care hospital psychiatric unit for admitting diagnoses of bipolar disorder, aggressiveness, and sexually inappropriate behaviors. The resident returned to the facility on 11/28/11 with orders for Seroquel 300 mg. daily, and remained on the medication until she was subsequently discharged from the facility to her home on 12/18/11, with orders for the Seroquel 300 mg. daily. In an interview on 12/20/11 at 2:00 P.M., the Director of Nursing confirmed that Resident #D did not receive any Seroquel following the 300 mg. dose on 11/8 until the medication was re-instated on 11/16/11. She indicated she would not			

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	have expected a nurse on evening or night shift on 11/8/11 to call the physician or Nurse Practitioner related to the clarification order on 11/5 for "... M.D. to evaluate for any change or new orders...." However, a licensed nurse should have called the physician or Nurse Practitioner for a follow-up the next day, 11/9/11, but "no one considered calling the doctor." This Federal tag relates to Complaint IN00100306. 3.1-35(g)(2)			