STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00375537. Complaint IN00375537 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: April 25, 26, 27, 28, and 29 2022. Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 35 SNF: 1 Total: 36 Census Payor Type: Medicare: 3 Medicaid: 24 Other: 9 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/2/22.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and	F 0554	**F 554 Self-Administration**	05/25/2022

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

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	interview, the facility failed to ensure residents had Physician's Orders and an assessment to self administer their own medications for 1 of 12 residents reviewed for self administration of medication. (Resident 10) Finding includes: On 4/25/22 at 10:24 a.m., LPN 1 was observed standing at the medication cart and Resident 10 was asking for a Tums tablet for heartburn. The LPN opened the medication cart and pulled out the bottle of Tums and poured 1 tablet into the plastic cup. At that time, the resident indicated he wanted 2 tablets. The LPN poured another tablet into the cup and gave the medication cup with 2 Tums' tablets to the resident. At that time, the resident took the cup and placed it in his shirt pocket and walked away. The LPN stated, "Are you going to take them now?" The resident stated, "No not right now." He started to walk away and the LPN stopped him again and stated "Ok then give me the cup back and I will hold them for you until you are ready to take them." The resident turned around and stated "Fine I will take one now" and put the tablet in his mouth, placed the medication cup with the other Tums tablet back in his shirt pocket and walked away. The LPN did not follow him to make sure he took the tablet. During an interview on 4/25/22 at 2:50 p.m., Resident 10 indicated the staff usually give him a "couple" of Tums and he could take them when he wanted to. At that time, there was a bottle of Artificial Tears eye drops with a facility label on the bottle on his over bed table. The resident indicated the nurses were supposed to put them in his eyes, but they gave him the bottle and now he does it himself.		Resident 10: A self-administration of medication assessment was not completed as resident declared on 4/28/22 that he did not want to be responsible to self-administer medications and agreed that he would take all medications in direct observation of Nurse/QMA. All residents are at risk to be affected by the deficient practice. The nurse managers will complete an audit of all resident's physician orders by 5/25/22 and if a resident has an order to self-administer or requests to self-administer medication/treatment the resident's ability to safely administer will be assessed. The assessment will be completed by the IDT by using the facility assessment tool "Self-Administration of Medication Assessment". The IDT will update/review resident's plan of care as pertinent to reflect ability to safely self-administer by 5/25/22. All residents residing in the facility will have their medications given by licensed personnel who will remain with the resident until medications have been taken in the presence of the licensed personnel unless they have been assessed and determined they are able to self-administer medications per facility policy. All licensed nursing staff /QMA's will be re-educated on the facility policies for	

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	The record for Resident 10 was reviewed on 4/26/22 at 12:35 p.m. Diagnoses included, but were not limited to, major depressive disorder, chronic pain, anxiety disorder, high blood pressure, pain disorder with related psychological factors. The Quarterly Minimum Data Set (MDS) assessment, dated 2/8/22, indicated the resident was cognitively intact. There was no care plan for the resident to self administer his own medications. There was no self administer of medication assessment noted in the clinical record. Physician's Orders, dated 9/9/20, indicated Artificial Tears Solution. Instill 1 drop in both eyes two times a day. The Medication Administration Record (MAR) for April 2022, indicated the Artificial Tears were administered at 6:15 a.m., and 9:00 p.m. The resident refused the eye drops at 6:15 a.m., on 4/13, 4/14, 4/25 and 4/26/22 and at 9:00 p.m., on 4/5, 4/10, 4/19, 4/22, and 4/23/22. Physician's Orders, dated 12/28/21, indicated Tums Tablet Chewable 500 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for heartburn unsupervised self administration. Interview with the Director of Nursing on 4/28/22 at 10:20 a.m., indicated there was no order for the resident to self administer his own medications, nor was there a self administration assessment for the resident to self administer.		"Medication Administration Procedure" and "Self-Administration of Meds & Assessment" on or before 5/25/22. Nurse managers and other Administration will make routine walking rounds to make direct observations that the policy is followed. The DON or other designee will be responsible to complete the QA tool titled "Quality of Care" (Attachment A). The tool will be completed daily x5 days, 3x weekly x 4 weeks, then weekly x 4weeks then monthly to monitor for ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days.	

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	3.1-11(a)			
F 0661 SS=A Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on record review and interview, the facility failed to ensure the discharge summary included the recapitulation of stay for 1 of 1 residents reviewed for discharge. (Resident 38)	F 0661	**F 661 Discharge Summary** Resident 38: discharged from facility. All residents are at risk to be affected by the deficient practice.	05/25/2022

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	Finding includes: The closed record for Resident 38 was reviewed on 4/29/22 at 9:22 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following surgical amputation, osteomyelitis (bone infection), type 2 diabetes mellitus, and schizoaffective disorder, bipolar type. The resident was admitted to the facility on 1/19/22 and discharged on 2/26/22. The Discharge Minimum Data Set (MDS) assessment, dated 2/26/22, indicated the resident planned to discharge to a home environment and return was not anticipated. The resident was cognitively intact. Nurses' Notes, dated 2/26/22 at 4:03 p.m., indicated the resident was ambulatory and he discharged home accompanied by his caregiver. All belongings and medications were sent home with the resident. The Nursing Discharge Plan of Care, Summary and Recap of Stay was dated 2/24/22 at 3:25 p.m. and signed as completed on 2/26/22 at 9:16 a.m. Section 7, Recap of Stay, indicated the resident was admitted for IV (intravenous) treatment. There was no other documentation regarding the resident's course of treatment while residing in the facility. Interview with the Director of Nursing on 4/29/22 at 11:00 a.m., indicated a recap of the resident's stay should have been documented and the discharge summary should not have been signed as completed prior to the resident being discharged.		The DON or other designee will complete an audit of all resident voluntary home/other facility discharges in past 30 days to review for completion discharge summary per facility policy. Licensed nurses will be in-serviced on or before 5/25/22 regarding the facility policy/procedure for "Voluntary Home/Other Facility Discharge". The discharging nurse will be responsible to complete the "Nursing-Discharge Plan of Care, Summary, and Recap of Stay Assessment" in the EMR prior to voluntary resident discharge to home or other facility. This assessment serves as the communication tool that documents discharge instructions provided to resident/responsible party, as well as, a facility discharge summary and recapitulation of the residents stay at the time of discharge. The completion of this assessment alerts the EMR 24-hour report. The DON or other designee will review the 24-hour report tool to monitor that policy/procedure for voluntary home/other facility discharge is followed. The DON or other designee will be responsible to complete the "Transfer and Discharge Review Tool" (Attachment H) daily x5 days, then 3x weekly for 2 weeks, then weekly on x6 weeks then monthly on an ongoing basis to ensure continued compliance.	

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	3.1-36(a)(1)		Any identified issues will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance of 95% for a minimum of 6 months	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcer treatments were performed as ordered by the Physician for 1 of 2 residents reviewed for pressure ulcers. (Resident 8) Finding includes: During a treatment on 4/29/22 at 9:30 a.m., Resident 8 was observed in bed. The Director of Nursing (DON), Hospice LPN 1 and CNA 1 were in the room and ready to change the resident's	F 0686	**F686 Treatment/Services to Prevent/Heal Pressure Ulcer** Resident 8: The resident suffered no adverse events from the practice. The treatment orders were clarified on 4/29/22 and will be provided as ordered by the physician. All residents have the potential to be affected by these deficient practices. The DON or other designee will	05/25/2022

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	bandages to the sacral, the right ankle and right medial foot pressure ulcers. All staff performed hand hygiene and donned clean gloves to both hands. The DON cut the kerlix bandage off of the right foot and threw it in the garbage can. There were 2 wounds noted to the right foot; the right ankle and the right medial foot. The right ankle was bloody with red tissue noted. The medial ulcer was pink and closed. The DON cleansed each area with normal saline and patted dry. She removed the Hydraferra Blue (provides wound protection and addresses bacteria and yeast by providing a moist wound environment) bandage from the wrapper and broke off 2 pieces. The DON moistened the bandages with plain water. She placed a piece of the blue bandage on the ankle and the medial right foot and wrapped the foot with the kerlix bandage and secured with tape. The record for Resident 8 was reviewed on 4/27/22 at 12:56 p.m. Diagnoses included but were not limited to, bipolar disorder, schizoaffective disorder, heart failure, chronic kidney disease, anxiety disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was moderately impaired for decision making. The resident had an acquired Stage 4 and 3 unstageable pressure ulcers. A Care Plan, dated 3/24/21, indicated the resident had wounds to the sacral area, left foot, and right ankle. The approaches were to administer treatments as ordered. Physician's Orders, dated 2/28/22, indicated right medial foot: cleanse with normal saline/wound cleanser pat dry, cover with betadine, cover with		complete a review of the physician's orders for all residents with areas of skin alterations by 5/25/22. The audit will ensure that the treatments are completed as ordered by the physician and per plan of care. The Charge nurse's will all be in-serviced by 5/25/22 on the importance of following physician's orders for the treatment of pressure injuries and the facility "Skin Management Policy". The DON or other designee will participate in walking rounds to make observations that physicians orders for the treatment of skin alterations are performed as ordered. The DON or other designee will be responsible to complete the QA tool titled "Quality of Care" (Attachment A). The tool will be completed daily x5 days, 3x weekly x 4 weeks, then weekly x 4weeks then monthly to monitor for ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days.	

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	foam wrap with rolled gauze every day shift on Monday, Wednesday, and Friday for wound care. Change dressing to right ankle three times a week and as needed on Monday, Wednesday, and Friday. Cleanse with normal saline and pat dry. Cover with Hydraferra Blue moistened with sterile water and cover with gauze, wrap with kerlix, secure with tape. Interview with the DON on 4/29/22 at 10:45 a.m., indicated she does not perform the treatments as the Hospice Nurses do and she was aware she had placed the Hydraferra Blue bandage on the right medial foot and it was to be betadine. 3.1-40(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 1 residents reviewed for oxygen. (Resident 23) Finding includes: On 4/25/22 at 10:30 a.m., and 1:30 p.m., Resident 23 was observed in bed wearing oxygen per nasal cannula. At that time, the flow rate on the	F 0695	**F 695** **Respiratory/Tracheostomy Care and Suctioning** Resident #23: Resident suffered no negative outcomes from the alleged deficient practice. Oxygen	05/25/2022

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	concentrator was set at 2.5 liters per minute. On 4/26/22 at 9:38 a.m., the resident was observed in bed wearing oxygen per nasal cannula. The flow rate was set at 2 liters per minute. On 4/26/22 at 1:16 p.m., and 2:30 p.m., the resident was observed in bed wearing oxygen per nasal cannula. The flow rate was set at 2.5 liters per minute. The record for Resident 23 was reviewed on 4/27/22 at 10:17 a.m. Diagnoses included, but were not limited to, stroke, major depressive disorder, type 2 dm, heart failure, chronic kidney disease, vascular dementia with behavioral disturbance, encephalopathy, sleep apnea, angina, obesity, and high blood pressure. The Quarterly Minimum Data Set)MDS), dated 3/15/22, indicated the resident was moderately impaired for decision making. He used oxygen as a resident. The Care Plan, updated 3/2022, indicated the resident had a respiratory failure condition with hypoxia and was on continuous oxygen. The approaches were administer oxygen as ordered. Physician's Orders, dated 3/18/22, indicated oxygen at 3 liters per minute via nasal cannula continuously. Interview with the Nurse Consultant on 4/28/22 at 1:30 p.m., indicated the oxygen flow rate should be at 3 liters per minute. 3.1-47(a)(6)		will be administered at the ordered rate of flow per physician's order and oxygen tubing will be changed and dated per policy to ensure ongoing compliance. All residents are at risk to be affected by the deficient practice. The DON completed an audit by 5/2522 of all residents utilizing oxygen to ensure physician's order for use, that oxygen is delivered at the correct ordered liter flow, and that oxygen is included in the resident's HCP. An all nursing staff in-service was held on or before 5/25/22 to review the "Oxygen Administration Protocol" and ensuring that residents using oxygen have physician's order for use. Charge nurses will be responsible to ensure that flow rates are set to ordered liter flow, tubing is changed weekly/prn and dated with each change, and updating HCP with any new physician's order for oxygen use. The charge nurses will participate in routine walking rounds during tour of duty to monitor residents receive oxygen as ordered and that	

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			oxygen tubing is changed/dated per policy. The DON or other designee will be responsible to complete the QA tool titled “Quality of Care Review” (Attachment A). The tool will be completed daily x5days, 3x weekly x 4 weeks, then weekly x 4weeks then monthly to monitor for ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, record review and interview, the facility failed to ensure as needed (prn) psychotropic medications were administered after interventions were attempted prior and opioid medication was given as ordered for 2 of 6 residents reviewed for unnecessary medications.	F 0758	**F758 Unnecessary Psychotropics** Resident 138: Resident suffered no negative outcomes from the deficient practice. Non-pharmacological	05/25/2022

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	(Residents 138 and 25) Findings include: 1. The record for Resident 138 was reviewed on 4/26/22 at 1:51 p.m. The resident was admitted to the facility on 4/6/22. Diagnoses included, but were not limited to, cancer of the esophagus, COPD, kidney failure, adult failure to thrive, high blood pressure, dementia with behaviors, anxiety, dysphagia, and schizophrenia. The Admission Minimum Data Set (MDS) assessment, dated 4/14/22 indicated the resident was not cognitively intact. In the last 7 days the resident had received anti-anxiety and opioid medication. Physician's Orders, dated 4/12/22, indicated Ativan (an anti-anxiety medication) Tablet 0.5 milligrams (mg). Give 0.5 mg via Peg-Tube every 6 hours as needed for anxiety/restlessness. The medication was discontinued on 4/19/22. The Medication Administration Record (MAR), dated 4/2022, indicated the Ativan was signed out as being administered on 4/13 at 10:15 p.m., 4/14 at 5:50 a.m., 5:49 p.m., and 11:50 p.m., 4/15 at 5:50 a.m., and 8:05 p.m., 4/16 at 6:30 a.m., and 4:30 p.m., 4/17 at 7:28 a.m., and 9:34 pm, 4/18 at 7:30 a.m., and 4/19 at 12:15 a.m. and 6:15 a.m. Physician's Orders, dated 4/19/22, indicated Ativan Tablet 0.5 mg. Give 0.5 mg via Peg-Tube every 6 hours as needed for anxiety/restlessness. The medication was discontinued on 4/25/22. The 4/2022 MAR indicated the Ativan was signed out as being administered on 4/19 11:00 p.m., 4/20 6:00 a.m., 4/21 at 11:30 p.m., 4/22 at 11:30 p.m., 4/23		interventions will be trialed and assessed for effectiveness prior to any administration of prn anxiolytics are administered. The interventions will be documented in the EMR. The order for prescribed opioid was clarified for the indication of pain on 4/25/22. Resident #25: Resident suffered no negative outcomes from the deficient practice. On 4/26/22 the residents medication orders were reviewed by the DON and the availability of ordered medications confirmed. The facility will ensure that the medication therapy continues as ordered and resident has adequate supply on hand in the facility by ensuring that an active prescription is maintained at the pharmacy. All residents are at risk to be affected by the deficient practice. The DON will complete an audit by 5/20/22 to ensure that any resident prescribed a medication that requires an active prescription has a supply on hand in the facility and that residents are receiving ordered medications as prescribed by the physician's order. PRN psychotropic medications and opioids will be reviewed to ensure proper indication for use is included in the physician's order. Any resident with an order for PRN psychotropic medication will be reviewed by the IDT by 5/20/22 to confirm the plan of care identifies	

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	at 8:10 a.m., 4/24 at 8:45 a.m., and 4/25 at 2:50 p.m. Physician's Orders, dated 4/13/22, indicated Percocet (an opioid medication) Tablet 5-325 mg. Give 1 tablet via Peg-Tube every 6 hours as needed for pain/agitation. The MAR for the month of 4/2022, indicated the Percocet was signed out as being administered on 4/13 at 10:15 p.m., 4/14 at 6:38 a.m., 5:49 p.m., and 11:50 p.m., 4/15 5:50 a.m., and 4:30 p.m. , 4/16 6:30 a.m., 6:30 p.m., 4/17 7:28 a.m., 4/18 2:08 am, 7:48 a.m., and 11:00 p.m., 4/19 5:00 a.m., 11:21 p.m., 4/22 11:30 p.m. 4/23 8:09 a.m., 4/24 8:45 a.m., 4/25 8:30 a.m., and 6:16 p.m. The MAR indicated on many days, the Ativan medication was given at the same time with the Percocet medication. Nursing Progress Notes, dated 4/12-4/25/22, indicated there was no documentation of interventions tried first before the administration of the as needed Ativan medication. Interview with the Director of Nursing on 4/28/22 at 10:15 a.m., indicated there was no documentation of interventions tried first before the administration of the prn Ativan. Nursing staff should have not administered both the Percocet and the Ativan medications at the same time. 2. On 4/25/22 at 1:47 p.m., Resident 25 was lying in bed in her room watching television. She indicated she had not received her Valium (diazepam, an anti-anxiety medication) yet today. Staff had told her "they don't have it" and had to wait for it to arrive from the pharmacy. She indicated this had happened in multiple times recently. She had been taking the medication		non-pharmacological interventions to be trialed and assessed by nursing prior to any use of PRN psychotropic medication administration. An all nursing staff in-service with Nurse's/QMA's will be completed on or before 5/25/22 to review the facility policy for "Psychotropic Drug Use Policy", "Medication Administration Procedures" and the importance of ensuring proper indication for use is clearly documented in physician's orders and assessed prior to administration of PRN opioids will be reviewed. An emphasis will be placed on reviewing that medication therapy using prn psychotropic medications should result in maintenance or improvement in the individual's mental, physical, or psychosocial well-being. Charge nurses will also be educated on monitoring the supplies on hand of resident medications that require prescriptions to help prevent depletion of supply without an active prescription. Charge nurses will be in-serviced on the importance of communicating with physician promptly upon discovery that a new prescription is needed to prevent interruption in resident's receipt of medications as ordered. Charge nurses will be instructed to document any new physician's order for PRN psychotropic medications or PRN opioids in the	

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	three times a day for years and needed it or she would have a panic attack. The record for Resident 25 was reviewed on 4/26/22 at 2:51 p.m. Diagnoses included, but were not limited to, anxiety disorder, schizoaffective disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/21/22, indicated the resident was cognitively intact. A Care Plan indicated the resident had mood issues, hallucinations, and paranoia. One of the interventions included to administer psychotropic medications as ordered. The Physician's Order Summary, dated 4/2022, indicated an order for Valium 5 milligrams (mg) every 8 hours for anxiety. The Medication Administration Record (MAR), dated 3/2022, indicated the Valium medication had not been signed out as administered on the following dates and times: - 6:15 a.m. on 3/17/22, 3/25/22, and 3/27/22. - 2:00 p.m. on 3/10/22, 3/15/22, 3/19/22, and 3/25/22. - 10:00 p.m. on 3/2/22 and 3/23/22. The Medication Administration Record (MAR), dated 4/2022, indicated the Valium medication had not been signed out as administered on the following dates and times: - 6:15 a.m. on 4/15/22 and 4/25/22. - 2:00 p.m. on 4/6/22. - 10:00 p.m. on 4/5/22 and 4/14/22. An electronic MAR note, dated 4/14/22 at 6:30 a.m., indicated the medication was not given on		EMR and on the 24hour report. The 24-hour report is reviewed routinely by the nurse managers and IDT team which serves as a communication tool for resident status changes. The nurse manager will assess and monitor for proper indication for use of PRN psychotropic and PRN opioid medication to prevent the use of unnecessary medications. The DON or other designee will be responsible to complete the "Medication Review Tool" (Attachment B). The tool will be completed on 5 residents per week for 6 weeks, then on 5% of census monthly to monitor for on-going compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QA tracking logs are reviewed by the team to ensure on-going compliance for a minimum of 6 months or until the facility maintains 95% compliance for 60days.	

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	4/14/22 at 6:15 a.m. due to waiting to get the medication from pharmacy. An electronic MAR note, dated 4/25/22 at 6:25 a.m., indicated the medication was not given on 4/25/22 at 6:15 a.m. because a new prescription was needed. Interview with the Director of Nursing (DON) and the Nurse Consultant on 4/28/22 at 9:58 a.m., indicated they were unsure why the medication had not been signed out on the MAR. There had to be an active prescription in order for the pharmacy to send a medication or for staff to pull a medication from the emergency supply. No further information was provided. 3.1-48(a)(6)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 13 residents observed during medication pass. Two errors were observed during 26 opportunities for errors during medication administration. This resulted in a medication error rate of 7.6%. (Residents 14 and 10) Findings include: 1. On 4/26/22 at 8:36 a.m., QMA 1 was observed preparing medications for Resident 14. A 5 milligram (mg) and a 10 mg Reglan (a medication used to treat gastroesophageal reflux) tablet was dispensed in the medication cup. The resident	F 0759	**F759 Free of Medication Error Rate 5% or More** Resident 14: The order for Reglan was clarified with the physician on 4/28/22. Resident will be administered medications as ordered. Resident 10: Resident had no negative outcome from the deficient practice. LPN 1 received 1:1 retraining on Med Pass Administration. All residents are at risk to be affected by the deficient practice. The DON will complete 1:1 re-education on medication pass	05/25/2022

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	received the Reglan along with her other medications at 8:44 a.m. The record for Resident 14 was reviewed on 4/26/22 at 9:30 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peptic ulcer. The April 2022 Physician's Order Summary (POS), indicated there was no order for the 10 mg of Reglan. Interview with the Nurse Consultant on 4/28/22 at 1:05 p.m., indicated the resident's medications were discontinued on 2/5/22 when she went on hospice. The resident switched to another hospice agency on 2/10 and the 15 mg of Reglan was reordered. The Physician was contacted on 4/28/22 and the order was clarified, he indicated it was okay to continue giving the 15 mg of Reglan. The Nurse Consultant indicated there should have been a Physician's order for the 10 mg dose of Reglan. 2. On 4/25/22 at 10:24 a.m., LPN 1 was observed standing at the medication cart and Resident 10 was asking for a Tums tablet for heartburn. The LPN opened the medication cart and pulled out the bottle of Tums and poured 1 tablet into the plastic cup and the resident indicated he wanted 2 tablets. The LPN poured another tablet into the cup and gave the medication cup with 2 Tums' tablets to the resident. At that time, the resident took the cup and placed it in his shirt pocket and walked away. The record for Resident 10 was reviewed on 4/26/22 at 12:35 p.m. Diagnoses included, but were not limited to, major depressive disorder, chronic pain, anxiety disorder, high blood pressure, pain disorder with related psychological factors.		procedure with QMA 1 and LPN 1 by 5/20/22 and complete a med pass observation to ensure other residents are not affected by the deficient practice. All nurse's and QMA's will be in-serviced on/or before "Medication Administration Procedure" by 5/25/22. To monitor the corrective actions and ensure the deficient practice does not recur the DON or other designee will complete the QA tool titled "Med Pass Observation Tool" (Attachment C). The tool will be completed on at least 3 randomly picked nurses or QMA's on varying shifts 3x weekly for 2 weeks, then weekly for 4 weeks, then monthly. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QA tracking logs are reviewed by the team to ensure on-going compliance for a minimum of 6 months or until the facility maintains 95% compliance for 60days.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 2/8/22, indicated the resident was cognitively intact. Physician's Orders, dated 12/28/21, indicated Tums Tablet Chewable 500 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for heartburn unsupervised self administration. Interview with the Director of Nursing on 4/28/22 at 10:20 a.m., indicated the resident was to receive only 1 Tums tablet as ordered by the Physician. 3.1-48(c)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of			

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	1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure inhalers and insulin vials were labeled and/or discarded after expiration for 1 of 1 treatment carts observed and 1 of 13 residents observed during medication pass. (Residents 35 and 15) Findings include: 1. On 4/28/22 at 8:37 a.m., LPN 2 was observed administering Resident 35's Anoro Ellipta inhaler. The resident was given 1 puff of the inhaler. The medication label on the box, indicated the resident was to receive 2 puffs. The record for Resident 35 was reviewed on 4/28/22 at 9:30 a.m. A Physician's Order, dated 8/21/21 and listed as current on the April 2022 Physician's Order Summary (POS), indicated the resident was to receive Anoro Ellipta Aerosol Powder Breath Activated 62.5-25 micrograms (mcg)/inhalation, inhale 1 puff orally one time a day for chronic obstructive pulmonary disease (COPD). Interview with the Nurse Consultant on 4/28/22 at 11:05 a.m., indicated the resident was to receive 1 puff of the inhaler and a label change was added to the box. She also indicated the order was clarified with the Physician and the resident was to receive 1 puff instead of 2. The pharmacy was contacted and a new inhaler was going to be sent out with the correct instructions. 2. On 4/29/22 at 10:15 a.m., Medication Cart 1 was	F 0761	**F761 Drug Records, Label/Store Drugs & Biologicals** Insulin vial was discarded upon discovery. A direction's change label was applied to the inhaler. All residents are at risk to be affected by this deficient practice. An audit was completed of all medication carts and medication storage rooms by 5/20/22 to ensure no items were being used beyond expiration date and all items are properly dated/labeled per policy. Nursing in-service with nurses/QMA's will be completed on or before 5/25/22 to review the process for utilizing direction change "Alert" labels to communicate to the nurse/QMA passing medications that an order specific direction may have changed since the medication was originally dispensed. Nurses will be instructed to place a date opened on all vials including insulin at the time the vial is used for the first time. Vials/Pens of insulin shall be discarded following the manufacturer's recommendations prior to expiration. A listing of expiration time frames from date opened for frequently used biologicals has been laminated and placed at	05/25/2022

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	observed on the West Unit with the Director of Nursing (DON). A multi-dose vial of Lantus insulin for Resident 15 was dated as being opened on 3/24/22. A label on the vial indicated it was to be discarded 28 days after opening. Interview with the DON at that time, indicated the insulin should have been discarded. 3.1-25(j)		nurses station for nurses to use as reference Nurses will be instructed to check dates each time prior to utilizing the product and if outdated to discard upon discovery. The DON or other designee will be responsible to complete the "Med cart/Med Room Audit Tool" (Attachment D/Attachment E) weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly thereafter on an ongoing basis to monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QA tracking logs are reviewed by the team to ensure on-going compliance for a minimum of 6 months or until the facility maintains 95% compliance for 60days	
F 0921 SS=B Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to dirty floors, stained privacy curtains, dirty over bed table stands, loose baseboards and torn floor mats for 2 of 2 units. (The East and West Units) Findings include:	F 0921	**F921** **Safe/Functional/Sanitary/Comfortable Environment** All residents are at risk to be affected by the deficient practice.	05/25/2022

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	During the Environmental Tour on 4/28/22 at 1:45 p.m., with the Maintenance Supervisor indicated the following: East Unit: a. Room E16 - The over bed table stand was dirty with dried enteral feeding. The floor around the baseboard was dirty. There was 1 resident who resided in the room. West Unit: a. Room W18-2 - The baseboard was falling off of the wall in the bathroom. There was a spider web in the corner of bathroom. There were spots of a black substance/ stain on the privacy curtain. Two residents shared the bathroom and the room. b. Room W15 - There was dirt adhered along the baseboards throughout the room. One resident resided in the room. c. Room W13 - There were holes in the floor mats beside both beds. There was dirt and debris noted along the baseboard by bed 1 and the bathroom floor was dirty. There were 2 residents who shared the bathroom and the room. d. Room W11 - The floor was dirty around the baseboard and in the corners by the closet. There were 2 residents who resided in the room. e. Room W10 - There was a large amount of debris and food on the floor behind and under bed 2. The over bed table stand was dirty with dried food noted. The bathroom floor was stained and the sink in the bathroom was falling off the wall and noted with loose caulking. There was adhered dirt on floor by doorway to bathroom. There were 2 residents who resided in the room		West Unit: Floor tiles in (118, 115, 113, 111, 110, 108) rooms and bathrooms were stripped cleaned/repaired. Room 118, the cove base (base board) was repaired and the room was deep cleaned by Housekeeping to remove all spider webs and replaced the privacy curtain. Room 115 and 111, the cove base was cleaned and both rooms were deep cleaned by Housekeeping. Room 113, the floor mat was discarded and replaced; the dirt and debris were removed by bed 1 and Housekeeping deep cleaned the room. Room 110, the bathroom sink was repaired and properly reattached to the wall and the caulking was replaced; the room was deep cleaned by Housekeeping. Room108 was deep cleaned by Housekeeping to remove all dirt beneath both resident beds. East Unit: Room (116) was deep cleaned by Housekeeping, including overbed table and baseboard. Additionally, Floor tiles in 116 in the room and bathroom floor were stripped cleaned/repaired. The Maintenance Director and other designated staff performed a walking environmental tour of the facility on 5/7/2022. The tour included inspection of bathroom ceiling vents, floor mats, bedside tables, floor tiles throughout	

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	and shared the bathroom. f. Room W8 - The floor was dirty under, beside, and behind both beds. There was adhered dirt noted along the baseboards. There were 2 residents who resided in the room. Interview with the Maintenance Supervisor on 4/28/22 at 2:00 p.m., indicated all of the above was in need of cleaning and/or repair. Interview with the Administrator on 4/28/22 at 2:07 p.m., indicated he was not aware of any complaints about the environment. This Federal tag relates to Complaint IN00375537. 3.1-19(f)		rooms/bathrooms, toilet paper holders, cleanliness of walls, observation of ceiling tiles, and any peeling/marred paint. Any identified issues were compiled onto a list for repair/cleaning and was completed by 5/7/2022. An all staff in-serviced was held on or before 5/25/22 on the policy of maintaining a functional, sanitary and comfortable environment. Staff will be instructed that upon discovery of any environmental concerns to report to immediate supervisor and a fill out request on “Maintenance Repair Log” (Attachment F). “Maintenance Repair Log” requests will be checked by the Maintenance Department daily to ensure timely repair. The Housekeeping Supervisor and or other designee will be responsible to conduct daily rounds using the “Room Rounds Checklist” (Attachment G) the checklist will be completed daily on 3 rooms per day for 1 week, 3x weekly for 3 rooms for 3 weeks, weekly on 3 rooms for 4 weeks, and then monthly by the Housekeeping Supervisor or other designee to monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6	

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			months and until the facility maintains 95% compliance for 60 days.	