		ID HUMAN SERVICES				FORM	APPROVED
							<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155102	B. WING			02/	24/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S	MERRY MANOR				335 OAKHILL AVE PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	This visit was for a R Licensure Survey.	ecertification and State					
	Survey dates: Februa 2023	ary 20, 21, 22, 23, & 24,					
	Facility number: 0000 Provider number: 155 AIM number: 100275	5073					
	Census Bed Type: SNF/NF: 50 SNF: 3 Total: 53						
	Census Payor Type: Medicare: 7 Medicaid: 34 Other: 12 Total: 53						
	These deficiencies re accordance with 410	flect State Findings cited in IAC 16.2-3.1.					
F 656 SS=D		comprehensive Care Plan	F	656			
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and	cility must develop and lensive person-centered sident, consistent with the th at §483.10(c)(2) and					
	 DIRECTOR'S OR PROVIDER/S	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.

PRINTED: 03/15/2023

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/15/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	E CONSTRUCTION	(X3) DATE	
		155102	B. WING		02/	24/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	
				35 OAKHILL AVE		
MILLER'S	MERRY MANOR		1	PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From page assessment. The con	e 1 nprehensive care plan must	F 656			
	describe the following) -				
		are to be furnished to attain ent's highest practicable				
		psychosocial well-being as				
		24, §483.25 or §483.40; and				
		would otherwise be required				
		.25 or §483.40 but are not				
	· ·	esident's exercise of rights				
	-	ding the right to refuse				
	treatment under §483	ervices or specialized				
		the nursing facility will				
	provide as a result of					
	· ·	a facility disagrees with the				
	findings of the PASAF	RR, it must indicate its				
	rationale in the reside					
		h the resident and the				
	resident's representat					
	(A) The resident's goard desired outcomes.	als for admission and				
		eference and potential for				
		ilities must document				
	-	s desire to return to the				
		ssed and any referrals to				
	local contact agencies	s and/or other appropriate				
	entities, for this purpo					
		n the comprehensive care				
		in accordance with the				
	section.	n in paragraph (c) of this				
		rvices provided or arranged				
		ined by the comprehensive				
	care plan, must-	, <u>F</u>				
		petent and trauma-informed.				
	This REQUIREMENT	is not met as evidenced				
	by:					
		n, record review, and				
	interview, the facility f	alled to develop a				

Facility ID: 000041

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 155102 B. WING 02/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE MILLER'S MERRY MANOR PLYMOUTH, IN 46563 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 2 F 656 person-centered care plan for 1 of 22 residents whose care plans were reviewed. (Resident 17) Finding includes: During an observation, on 2/21/2023 at 9:53 A.M., Resident 17's left right was very edematous, and scratches were noted. Resident 17 indicated his leg itched sometimes and he scratched it earlier that morning. A clinical record review, done on 2/23/2023 at 9:58 A.M., Resident 17's Admission MDS (Minimum Data Set) Assessment, dated 2/10/2023, indicated, a BIMS (Brief Interview of Mental Status) was 15, which indicated no impairment. His active diagnoses included, but were not limited to, diabetes mellitus. He required extensive assist of 2 staff for bed mobility, transfers, and toileting, and extensive assist of 1 staff for dressing. He had a surgical wound with wound care due to a knee replacement. No pressure ulcers or other skin conditions were noted. Other diagnoses included, but were not limited to, unspecified edema. Physician orders for Resident 17 included, but were not limited to, on 2/3/2023 burnetanide 1 mg (milligram), a diuretic; on 2/3/2023 hydrochlorothiazide 25 mg, a diuretic; and on 2/6/2023 a moisture barrier cream to his buttocks and perineal area. A care plan problem, dated 2/14/2023, indicated, but was not limited to, edema to his lower extremities. Interventions included, but were not limited to, administer medication as ordered;

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 000041

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PRINTED: 03/15/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/15/2023 RM APPROVED IO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
1		155102	B. WING		0:	2/24/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MILLER'S	MERRY MANOR			635 OAKHILL AVE PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656 F 657 SS=D	assist to elevate legs; notify physician as ne scratches to his right I During an interview, o LPN 8 indicated there scratches but there sh A policy titled, "Care F Review" and dated, 1, the Director of Nursing The policy indicated, I Show evidence that provided are to attain highest practicable ph psychosocial well-bein 3.1-35(d)(1)(2)(A) Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident.	and observe edema and beded. A care plan for the leg was not found. In 2/23/2023 at 2:08 P.M., was no care plan for the hould have been. Plan Development and /24/202, was provided by g on, 2/23/2023 at 4:19 P.M. but was not limited to, " treatment or services or maintain the resident's hysical, mental, and ng" I Revision (i)-(iii) ensive Care Plans orehensive care plan must a days after completion of seessment. terdisciplinary team, that ited to vsician. e with responsibility for the responsibility for the	F 65	6		
	(E) To the extent prac the resident and the re An explanation must b	and nutrition services staff. eticable, the participation of esident's representative(s). be included in a resident's participation of the resident				

Facility ID: 000041

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	-					FORM	0: 03/15/2023
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		155102	B. WING		_	02/2	24/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MILLER'S	MERRY MANOR		-	35 OAKHILL AVE PLYMOUTH, IN 46563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on record revi review, the facility fail- the use of an antidep 22 residents whose of Resident 31)\ Finding includes: A clinical record revie 2/23/2023 at 9:51 A.M included, but were no malnutrition, insomnia prostate. A Quarterly MDS, dat resident required exter bed mobility, toilet use eating and total assist antianxiety and antide was receiving Hospical A current care plan, d the resident had sleep a routine medication p (trazadone).	resentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the juarterly review is not met as evidenced iew, observation and record ed to revise a care plan for ressant medication in 1 of care plans were reviewed. (w was completed on, <i>A</i> . Resident 31's diagnoses it limited to: dementia, a, dysphagia, and benign ed 1/4/2023, indicated the ensive assist of 2 staff for e, 1 staff for dressing and t for transfers. Received epressant medications and e services. lated 12/23/2022, indicated plessness/insomnia and had	F 657				

	-					FORM	: 03/15/2023 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		155102	B. WING			02/2	24/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MILLER'S	MERRY MANOR			35 OAKHILL AVE LYMOUTH, IN 46563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657 F 684 SS=D	the previous order for discontinued on 2/7/20 A NP (Nurse Practition indicated she did a GI for the residents' traza stopped. During an interview, of the Director of Nursing was not updated and On 2/23/2023 at 4:19 Nursing provided the Development and Rev indicated the policy withe facility. The policy Revision: A. Care plan PRN as changes in the dictate. Changes inclu- changes in Physician 3.1-35(d)(2)(b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fur applies to all treatment facility residents. Base assessment of a resid that residents receive accordance with profe practice, the compreh care plan, and the residents	trazadone was 023. ner) Note, dated 2/7/2023, DR(gradual dose reduction) adone. Medication is to be on 2/23/2023 at 10:50 A.M., g indicated the care plan should have been. P.M., the Director of policy titled, "Care Plan view", dated 1/24/2020, and as the one currently used by indicated" 3. Care Plan ns will be revised daily and he resident's condition ude but are not limited to orders" are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of iensive person-centered sidents' choices.	F 657				
	This REQUIREMENT	is not met as evidenced					

Event ID: X7N111

Facility ID: 000041

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/15/2023 M APPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		155102	B. WING		02	/24/2023
NAME OF PF	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
MILLER'S	MERRY MANOR			635 OAKHILL AVE PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 684	Based on observation record review, the fact out of 22 residents re- and care in accordance standards of practice care plan. (Resident of Finding includes: During an observation Resident 17's right less scratches were noted leg itched sometimes that morning. During a clinical record 2/23/2023 at 9:58 A.M MDS (Minimum Data 2/10/2023, indicated, BIMS (Brief Interview which indicated no im diagnoses included, b diabetes mellitus. He 2 staff for bed mobility and extensive assist of had a surgical wound knee replacement. No skin conditions were re included, but were no edema. Physician orders for F were not limited to, or (milligram), a diuretic; hydrochlorothiazide 2 2/6/2023 a moisture b	n, interview, and clinical clity failed to ensure that 1 viewed received treatment ce with professional and the comprehensive 17) n, on 2/21/2023 at 9:53 A.M., g was very edematous, and l. Resident 17 indicated his and he scratched it earlier rd review, done on <i>A.</i> , Resident 17's Admission Set) Assessment, dated but was not limited to, a of Mental Status) was 15, npairment. His active but were not limited to, required extensive assist of y, transfers, and toileting, of 1 staff for dressing. He with wound care due to a o pressure ulcers or other noted. Other diagnoses at limited to, unspecified Resident 17 included, but n 2/3/2023 bumetanide 1 mg ; on 2/3/2023 25 mg, a diuretic; and on barrier cream to his buttocks o orders were found for	F 684			

Facility ID: 000041

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/15/2023 M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		155102	B. WING		02	/24/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MILLER'S	MERRY MANOR			635 OAKHILL AVE PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	A care plan problem, Resident 17 indicated edema to his lower ex- included, but were no medication as ordered observe edema and r Another care plan pro Resident 17 indicated risk for breakdown. In were not limited to, m and notify physician a skin integrity. Daily nursing assess 2/21/2023, 2/22/2023 but were not limited to skin issues. During an interview of LPN 8 indicated she issues on resident 17 that night shift does d skin assessment wou check of resident's sk An observation of Res on, 2/23/2023 at 3:25 were red with several A policy titled "Chartin 4/15/2014, provided b 2/24/2023 at 10:30 A. limited to, "Any new symptom or complain EMR (electronic medi SBAR (Situation, Bac	dated 2/14/2023, for I, but was not limited to, stremities. Interventions t limited to, administer d; assist to elevate legs; and notify physician as needed. bblem, dated 2/3/2023, for I, but was not limited to, skin iterventions included but onitor skin daily during care and family of any change in ments for Resident 17, dated , and 2/23/2023, indicated o, skin checks with no new n, 2/23/2023 at 2:08 P.M., was not aware of any skin 's legs. She also indicated aily assessments and that a Id include a head to toe in. sident 17's legs with LPN 8 P.M., indicated his legs scratches. ng Procedure" and dated, by the Director of Nursing on, M., indicated, but was not v physical or emotional t will be documented in the ical record). Use of the kground, Assessment, and I to communicate changes	F 684			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/15/2023 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155102	B. WING			_	02/2	24/2023
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STA	ATE, ZIP CODE		
MILLER'S MERRY MANOR					OAKHILL AVE (MOUTH, IN 46563			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	F 6 1		PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		COMPLETION DATE
F 684	Continued From page	8	F	684				
	3.1-37(a)							

Event ID: X7N111

Facility ID: 000041

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