STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	3530 MONROE STREET LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00404696. Complaint IN00404696 - No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12, 13, and 14, 2023 Facility number: 000194 Provider number: 155297 AIM number: 100267790 Census Bed Type: SNF/NF: 39 SNF: 16 Total: 55 Census Payor Type: Medicare: 18 Medicaid: 15 Other: 22 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/21/23.	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 interview, the facility failed to ensure residents	F 0554	**F554 Resident Self-Admin Meds-Clinically Appropriate**	05/05/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Mitchell	Administrator	05/05/2023

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	had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Residents 36) Finding includes: On 4/10/23 at 9:42 a.m., Resident 36 was observed in bed. There was a container of Bacitracin ointment on a bedside table. The resident indicated the staff were applying it to his bottom at one time because it was reddened. On 4/11/23 at 9:57 a.m., the Bacitracin ointment was observed on a bedside table. On 4/12/23 at 11:39 a.m., the Bacitracin ointment was observed on a bedside table. Resident 36's record was reviewed on 4/12/23 at 1:23 p.m. Diagnoses included, but were not limited to, heart attack, heart failure, and renal insufficiency. The Quarterly Minimum Data Set (MDS) assessment, dated 1/11/23, indicated the resident was cognitively intact for daily decision making. There were no Physician's Orders for the Bacitracin ointment. There was no self-administration assessment of medication assessments completed for the resident. Interview with the Director of Nursing on 4/13/23 at 2:45 p.m., indicated the resident did not have an order for the Bacitracin so she was unsure where he would have obtained the medication.		It is the policy of Miller's Health & Rehab La Porte to ensure that residents have Physician Orders for medication and an assessment to self-administer their own medications. Resident #36 had the bacitracin removed immediately from his room on 4/13/2023 due to no active order or a need for the order. All residents residing in the facility have the potential to be affected by the deficient practice. All residents' rooms were inspected to observe for any medications left at the bedside on or before May 5, 2023. Any medication found was removed and taken to the nurse for proper storage and compared to Physician Orders. Any items not approved All licensed nursing staff /QMA's will be re-educated on or before May 5, 2023 on the "Medication Administration" policy and procedure (Attachment A). 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 "Nursing Services QA Review". This tool will be	

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	3.1-11(a)		completed 5x week x 4 weeks, weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool “Nursing Services QA Review” (ATTACHMENT B) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse			

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	consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, record review and interview, the facility failed to ensure the Physician was notified of treatment refusals for 1 of 1 residents reviewed for notification of change. (Resident 8) Finding includes:	F 0580	**F580 Notify of Changes** It is the policy of Miller's Health & Rehab La Porte to ensure the Physician is notified of treatment refusals. Resident #8 had order changes from the Physician with	05/05/2023

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	On 4/11/23 at 9:45 a.m., Resident 8 was observed in her room in bed. Her left elbow area did not have an ace wrap in place. On 4/12/23 at 10:33 a.m. and 1:52 p.m., the resident was observed in her room in bed. There was no ace wrap in use to the left elbow area. On 4/13/23 at 9:15 a.m., the resident was observed in her room in bed. There was no ace wrap in use to the left elbow area. The record for Resident 8 was reviewed on 4/11/23 at 1:20 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and contracture (tightening of the muscles and tendons that cause the joints to become stiff) of the left elbow. The Quarterly Minimum Data Set (MDS) assessment, dated 3/21/23, indicated the resident was cognitively impaired for daily decision making and she had a functional limitation in range of motion (ROM) to one side of the upper extremities. A Physician's Order, dated 2/24/23, indicated the resident had left elbow edema and a gel pad was to be applied directly to the elbow and the elbow was to be wrapped with an ace bandage for compression every day and remove at night. The April 2023 Treatment Administration Record (TAR) indicated the resident refused the treatment on 4/1, 4/2, 4/3, 4/4, 4/5, 4/9, 4/10, 4/11, 4/12, and 4/13/23. There was no documentation indicating the Physician had been notified of the treatment		notification of refusals as of April 27th 2023 regarding ace wrap use on the left elbow area. All residents residing in the facility have the potential to be affected by the deficient practice. All residents MAR's/TAR's were audited for the last 30 days specific to refusals. Those with 3 consecutive days of refusals the physician was contacted and made aware of the refusal on or before May 5, 2023. All licensed nursing staff were educated on or before May 5, 2023 on the "Medication Refusal" policy and procedure (Attachment C). The DON or designee will be responsible to complete the QA tool "Medication/Treatment QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Medication/Treatment QA Review" (ATTACHMENT D) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA	

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	refusals. Interview with the Director of Nursing on 4/14/23 at 12:20 p.m., indicated the Physician should have been notified of the resident refusals. 3.1-5(a)(2)		tracking log and reported during monthly QA Committee meeting.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received the necessary care to maintain Activities of Daily Living (ADLs) related to turning and repositioning in bed and dirty fingernails for 2 of 4 residents reviewed for ADLs. (Residents 164 and 36) Findings include: 1. During an interview on 4/10/23 at 11:02 a.m., Resident 164 indicated a couple nights ago, the CNAs put him to bed with the hoyer lift and left the pad underneath him. The hoyer pad remained underneath him until the next morning. He has asked staff to be turned and repositioned but they do not come back to help him and he cannot do it by himself. The resident indicated the midnight shift was the worst, they do not come and turn him like he should be. During an interview on 4/11/23 at 9:55 a.m., the resident indicated getting turned at night time was still a problem.	F 0677	**F677 ADL Care Provided for Dependent Residents** It is the policy of Miller's Health & Rehab La Porte to ensure dependent residents receive the necessary care to maintain Activities of Daily Living (ADLs) related to turning and repositioning in bed and dirty fingernails. Resident #164 had a plan of care implemented for turning and repositioning on April 14th, 2023 with turning and repositioning every 2-3 hours with staff assistance. Resident #36 had his nails cleaned and trimmed on April 11, 2023 upon discovery of the need for nail care. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers and other Administration completed walking	05/05/2023

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	The record for Resident 164 was reviewed on 4/11/23 at 2:10 p.m. The resident was readmitted to the facility on 3/23/23. Diagnoses included, but were not limited to, necrotizing fasciitis, chronic pain, cellulitis of the upper limb, neuromuscular of the bladder, prostate and stomach cancer. The Admission Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was cognitively intact and had an indwelling foley (urinary) catheter. The resident was an extensive assist with a 2 person physical assist for bed mobility and transfers. The Care Plan, dated 3/13/23, indicated the needed assistance with all ADLs, including bed mobility, eating, toileting and transfers. The bed mobility in the electronic charting point of care task section, completed by the CNA, indicated bed mobility: self performance - "How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture." In the last 30 days the following was documented for bed mobility (when the resident was turned and repositioned): 3/14/23 at 2:48 p.m. 3/17/23 at 10:16 a.m. and 5:15 p.m. 3/19/23 at 9:43 a.m., 7:52 p.m., and 11:39 p.m. 3/20/23 12:29 p.m. 3/23/23 9:11 p.m. and 11:27 p.m. 3/24/23 11:12 a.m. and 4:02 p.m. 3/28/23 9:26 a.m. and 10:33 p.m. 3/30/23 11:24 a.m. and 8:13 p.m. 4/5/23 10:33 a.m. and 9:26 p.m. 4/9/23 1:30 p.m. and 3:02 p.m. 4/10/23 5:17 a.m., 12:12 p.m., and 9:40 p.m. 4/11/23 6:26 p.m., 10:04 a.m., and 4:14 p.m. 4/12/23 1:39 a.m. and 7:53 a.m.		rounds and assessed all residents' nails. Trimming and cleaning was completed if needed. All residents care tasks were audited for documentation on turning and repositioning and added if needed. Both tasks were completed on or before May 5, 2023. All staff were reminded to alert nursing staff if residents were seen with dirty nails. Nursing staff were re-educated on or before May 5, 2023 on the "Nail Care" policy and procedure. (Attachment E). All nursing staff will be educated on or before May 5, 2023 on the "Skin Management Program" policy and procedure (Attachment F) The DON or designee will be responsible to complete QA tool "Nursing Services QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Nursing Services QA Review" (ATTACHMENT B) specifically monitoring care plan accuracy and revision. Any identified trends will	

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	There was no documentation on 3/21 or 3/22/23 the resident was turned or repositioned. Interview with the Director of Nursing on 4/13/23 at 10:15 a.m., indicated the documentation of the resident being turned and repositioned was lacking in the clinical record. All residents should be turned and repositioned every 2 hours.2. On 4/10/23 at 9:42 a.m., Resident 36 was observed in bed. His fingernails were long and there was an accumulation of dirt underneath them. Resident 36's record was reviewed on 4/12/23 at 1:23 p.m. Diagnoses included, but were not limited to, heart attack, heart failure, and renal insufficiency. The Quarterly Minimum Data Set (MDS) assessment, dated 1/11/23, indicated the resident was cognitively intact for daily decision making. He required extensive assistance with two persons physical assist for bed mobility, transfer, and toilet use. He required limited assistance with one person physical assist for personal hygiene. Interview with the Director of Nursing on 4/13/23 at 2:45 p.m., indicated the resident's fingernails should have been cleaned and trimmed. 3.1-38(a)(3)(E) 3.1-38(b)(6)		be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored, and geri-sleeves (protective skin sleeves) were applied as ordered for 1 of 1 residents reviewed for anticoagulant (blood thinning) medication side effects and 2 of 3 residents reviewed for skin conditions non-pressure related. (Residents 30, 22, and 33) Findings include: 1. On 4/10/23 at 2:05 p.m., Resident 30 was observed with a large area of reddish/purplish discoloration to his right forearm, no geri-sleeves were in use at that time. The record for Resident 30 was reviewed on 4/12/23 at 11:49 a.m. Diagnoses included, but were not limited to, stroke and muscle weakness. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 3/25/23, indicated the resident required extensive assist with bed mobility and transfers. The resident had also received an anticoagulant medication within the last 7 days. A Care Plan, reviewed on 3/9/23, indicated the resident was at risk for developing skin tears and/or bruises due to decreased subcutaneous tissue secondary to the aging process and other disease processes. Interventions included, but were not limited to, apply geri-sleeves. A Physician's Order, dated 8/16/19 and listed as current on the April 2023 Physician's Order	F 0684	**F684 Quality of Care** It is the policy of Miller's Health & Rehab La Porte to ensure areas of bruising were assessed and monitored and geri-sleeves were applied as ordered for skin conditions non-pressure related. Resident #30 he had a skin assessment completed on 4/11/2023 noting bruising to right forearm and hand x7 days and Geri sleeves were placed on resident. Residents #22 had bruising that was noted at admission measured on 4/12/2023 upon return from 4/10/23 transfer to the hospital. Resident #33 no longer resides at the facility. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers completed a head to toe skin assessment on all residents on 4/11/2023. All abnormal findings had MD and RP notification with follow up on 4/11/2023. All nursing staff were re-educated on or before May 5, 2023 on the "Wound and Non-wound Assessment & Documentation" policy and procedure (Attachment G). The DON or designee will be	05/05/2023

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	Summary (POS), indicated the resident was to have geri-sleeves to the bilateral upper extremities every shift for skin protection and they could be removed for hygiene. A Physician's Order, dated 3/18/23, indicated the resident was to receive Eliquis (a blood thinner) 5 milligrams (mg) twice a day. A Physician's Order, dated 4/11/23, indicated to monitor the bruise to the right forearm/ hand x 7 days. Monitor for signs and symptoms of infection, increased pain, or unusual changes and report to the Physician every shift for 7 days. A Nursing Weekly Assessment, dated 4/5/23, indicated the resident had old bruising to his bilateral upper extremities. A Nursing Occurrence Initial Assessment, dated 4/11/23 at 4:02 p.m., indicated the resident had bruising to his right forearm and hand that measured 7 centimeters (cm) x 4 cm. The bruising was to be monitored every shift. Interview with the Director of Nursing on 4/12/23 at 2:00 p.m., indicated orders to monitor the bruising should have been obtained and the area assessed when it was first noted. She also indicated the resident should have been wearing his geri-sleeves. 2. On 4/10/23 at 1:44 p.m., Resident 22 was observed sitting in her wheelchair. At that time, both of her hands and upper arms were observed with deep dark blue and red discolorations. The resident was admitted to the hospital on 4/10/23 and returned on 4/12/23. The record for Resident 22 was reviewed on		responsible to complete QA tool "Skin Management QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Skin Management QA Review" (ATTACHMENT H) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	4/11/23 at 1:30 p.m. The resident was admitted to the facility on 2/28/23. Diagnoses included, but were not limited to, heart failure, fracture of the right knee, iron deficiency anemia, heart disease, atrial fibrillation, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 3/7/23, indicated the resident was cognitively intact. In the last 7 days, the resident received an anticoagulant medication 7 times. The Care Plan, dated 2/28/23, indicated the resident was receiving an anticoagulant medication for atrial fibrillation. The approaches were to monitor for signs and symptoms of bruising. Physician's Orders, dated 2/28/23, indicated Apixaban (an anticoagulant medication) oral tablet 2.5 milligrams (mg). Give 1 tablet by mouth two times a day for clot prevention. A Nursing Admission Assessment, dated 2/28/23 indicated the resident had no bruising or dark discoloration anywhere. The resident was admitted to the hospital on 4/5/23 for increased edema and drainage to the lower legs. A skin tear was documented on the e-Interact Change in Condition Evaluation. There was no documentation regarding any bruising when the resident was sent to the hospital. A Nursing Acute Return From Short Term Stay Assessment, dated 4/7/23, indicated the resident had no bruising anywhere and only was observed with a skin tear. A late entry, documented on 4/11/23 at 3:10 p.m.			

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	155297	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	3530 MONROE STREET LA PORTE, IN 46350

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	on the Nursing Acute Return From Short Term Stay Assessment, indicated dark purple discoloration noted to bilateral hands, forearms, and bilateral lower extremities. There were no measurements of the bruising. A Nursing-Assess Skilled Form, dated 4/8/23 at 12:59 a.m., 9:59 a.m., 5:35 p.m., on 4/9/23 at 12:43 a.m., 9:43 a.m., and 3:45 p.m., and on 4/10/23 at 5:25 a.m., and 2:08 p.m. all indicated the resident had no bruising anywhere. There was no documentation on 4/2023 Treatment Administration Record (TAR) the bruises were monitored for 7 days after admission. Interview with CNA 2 on 4/10/23 at 2:30 p.m., indicated the resident has had those dark discolorations to both of her hands "for a while." Interview with a Senior Director of Nursing from a sister facility on 4/12/23 at 11:15 a.m., indicated the nurse went back and made a late entry on what she remembered from the resident's readmission on 4/7/23. There were no measurements of the bruises. 3. On 4/10/23 at 10:50 a.m., Resident 33 was observed in her room, sitting in a wheelchair. At that time, the back of each of her hands were discolored with red and purple areas. On 4/11/23 at 1:04 p.m., the resident was observed walking with therapy in the hallway. The red and purple discoloration remained to the back of each hand. The record for Resident 33 was reviewed on 4/11/23 at 1:11 p.m. Diagnoses included, but were not limited to, fractured femur, anxiety, and high			

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	blood pressure. The 5 Day Medicare Minimum Data Set (MDS) assessment, dated 3/7/23, indicated the resident was moderately impaired for decision making. A Care Plan, dated 11/30/22, indicated the resident was at risk for skin breakdown. The approaches were to monitor skin daily during care. There was no documentation in nursing notes regarding discoloration to the back of both hands. A Nursing-Weekly Assessment, dated 3/27/23, indicated the resident had no skin issues. A Nursing-Assess Skilled Form, dated 4/5/23 and 4/10/23 indicated the resident had no bruising, rashes or excoriation. There were no Physician's Orders to monitor any discoloration to the back of her hands. The 4/2023 Treatment Administration Record (TAR) lacked documentation to monitor any bruising. A facility Post Occurrence IDT and Fall Risk Assessment Form, dated 4/12/23, at 8:42 a.m., indicated on 4/11/23 at 4:00 p.m., the resident was found to have bruising to top of right and left hand. "The resident stated I get these all the time. They are nothing just leave them alone. They don't bother me." The resident was encouraged to wear geri-sleeves, however, she indicated she does not need or want them. She was also encouraged to wear long sleeves or a sweater. The root cause for the bruising was the resident had a long history of steroid use due to respiratory issues, so the skin			

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	was fragile and bruised easily. Interview with the Senior Director of Nursing (DON) from a sister facility on 4/12/23 at 11:15 a.m., indicated there was no documentation of the bruising to the back of the resident's hands prior to 4/11/23. The current 5/17/17 "Wound [Pressure Injury] and Non Wound Assessment and Documentation" policy, provided by the Senior DON on 4/12/23 at 12:00 p.m., indicated all non wound skin alterations will be managed by the licensed staff nurses. Initial assessment and documentation will e completed on the Nursing-New Skin Alteration Assessment or if on a new admit on the Nursing-Admission/Return Assessment. The non-wound area will be placed on the TAR with instructions to monitor at least daily until it was healed. Bruises will be monitored at least daily times 7 days for complications such as pain that may indicate need for further assessment. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of			

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	vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure residents received proper treatment and assistive devices to maintain hearing abilities related to not monitoring and assisting with a resident's hearing aid for 1 of 1 resident reviewed for hearing. (Resident 23) Finding includes: Interview with Resident 23 on 4/10/23 at 11:08 a.m., indicated the resident had difficulty with hearing and would like hearing aids. During a follow up interview on 4/11/23 at 1:40 PM, the resident indicated she wished she could hear the television. Resident 23's record was reviewed on 4/11/23 at 1:08 p.m.. Diagnoses included, but were not limited to, type 2 diabetes, transient cerebral ischemic attack, major depressive disorder, hypertension, dysphasia, and slurred speech. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact. She required moderate assistance with activities of daily living and had minimal difficulty with hearing. The record lacked documentation related to the resident wearing hearing aids. Interview with LPN 1 on 4/12/23 at 11:35 a.m., indicated the resident never expressed she had issues with hearing, but LPN 1 did have to speak louder for her. Interview with the Activity Director/ Social Service (SS) designee on 4/12/23 at 1:28 p.m.,	F 0685	**F685 Treatment/Devices to Maintain Hearing/Vision** It is the policy of Miller's Health & Rehab La Porte to ensure residents received proper treatment and assistive devices to maintain hearing abilities and assisting with a resident's hearing aid. Resident #23's RP was notified on 4/12/2023 regarding eval for hearing aids. Outside services were offered on this date and both the resident and son declined outside services for audiology and have chose to wait until May 15, 2023 when contracted audiology will make a visit. The RP removed the hearing aides from Resident #23 as they were not her hearing aids. All residents residing in the facility have the potential to be affected by the deficient practice. All residents' assessments (MDS) in the last 90 days, specifically section B0200 – ability to hear, who trigger moderate difficulty or highly impaired as it relates to hearing were assessed to determine the need for additional audiology visits on or before May 5, 2023. All residents were audited on or before May 5, 2023 for use of hearing aides and orders placed for care of hearing aid. All nursing and Social Services staff educated on or before May 5,	05/05/2023

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	indicated the resident was supposed to have an audiology appointment in February. The audiologist was to reschedule the appointment. She had spoken to the resident's son and he observed the resident was wearing her deceased husband's hearing aids. An appointment had not been rescheduled for audiology. The Activity Director/SS designee indicated a call was made today and there was not a return call back yet. Interview with the Social Service Director (SSD) on 4/12/23 at 1:51 p.m., indicated she was not aware the resident had been wearing her deceased husband's hearing aids. Audiology was contacted today and they were waiting on a return call. The resident was on the list to be seen. The SSD indicated it was not uncommon for audiology to wait 2 months before they return to the facility once called. Family can have the resident sent out to an audiologist if they would like, but it would be an extra charge. Audiology liked to come to the facility to see residents in a group to make sure pay was covered. She was not aware of this resident's hearing issues and will contact the son to see if he would like her to go out for an appointment. Follow up interview with the Activity Director/SS designee on 4/14/23 at 11:06 a.m., indicated audiology will be in the facility on May 13, 2023 and the resident was on the list to be seen. 3.1-39(a)		2023 on the "Hearing Services" protocol. (Attachment I). Social Services Designee will be responsible to complete the QA tool "Hearing QA Review" 1x week x 4 weeks, then monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Hearing Review" (ATTACHMENT J) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents with a history of weight loss and supplements not provided as ordered for 1 of 1 residents reviewed for nutrition. (Resident 19) Finding includes: Interview with Resident 19 on 4/10/23 at 3:00 p.m., indicated she had lost weight and she was not always offered her supplement. The record for Resident 19 was reviewed on 4/13/23 at 8:53 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dysphagia (difficulty swallowing), and gastroesophageal reflux disease (GERD). The Quarterly Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident	F 0692	**F692 Nutrition/Hydration Status Maintenance** It is the policy of Miller's Health & Rehab La Porte to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records and supplements not provided as ordered. Resident #19 had her order for Ensure Clear discontinued due to repeated refusals on 4/27/2023. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers audited all residents with commercial supplement orders to ensure acceptance of these supplements are occurring and follow up with MD if there are concerns noted on	05/05/2023

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	was cognitively intact and required supervision with eating. The resident also had a significant weight loss and was receiving a therapeutic diet. A Care Plan, reviewed on 2/2023, indicated the resident was at nutritional risk related to not always making healthy meal choices, weight fluctuations due to stomach problems, multiple dislikes/ intolerances, and having a weight loss of 10% in the last 6 months. Interventions included, but were not limited to, offer replacement for food/beverages not consumed or if she consumed 50% or less of a meal and monitor weights and intakes. On 10/7/22 the resident weighed 167 pounds. On 4/12/23, the resident weighed 136 pounds. A Physician's Order, dated 2/15/23, indicated the resident was to receive Ensure Clear with meals, 8 ounces three times daily. The Food Consumption logs for March and April 2023, indicated there was no food consumption documented on the following dates: - No dinner was documented on 3/23 and 3/27/23 - No breakfast or lunch was documented on 4/4 and 4/5/23 - No lunch was documented on 4/11/23 The March 2023 Medication Administration Record (MAR), indicated there was no documentation related to the Ensure being offered on the following dates and times: - 3/20/23 at 8:00 a.m. and 12:00 p.m. - 3/23 and 3/26/23 at 12:00 p.m. and 5:00 p.m. - 3/26/23 at 12:00 p.m. - 3/4, 3/5, 3/18, 3/19, and 3/25/23 at 5:00 p.m. The April 2023 MAR, indicated there was no		or before May 5, 2023. All licensed nursing staff were educated on or before May 5, 2023 on the “Nutritional Oral Supplements” policy and procedure (Attachment K) and on the “Point of Care Documentation and Legends” (Attachment L) The DON or designee will be responsible to complete the QA tool “Nutrition/Hydration Status Review” 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool “Nutrition/Hydration Status Review” (ATTACHMENT M) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee.	

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	documentation related to the Ensure being offered on the following dates and times: - 4/4 and 4/6/23 at 12:00 p.m. - 4/1 and 4/5/23 at 5:00 p.m. Interview with the Director of Nursing on 4/14/23 at 9:25 a.m., indicated the resident's food consumption logs should have been completed and her Ensure should have been documented as being offered. 3.1-46(a)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility	F 0757	**F757 Drug Regimen is free from**	05/05/2023

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	failed to manage medications appropriately related to administering medications as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Finding includes: Resident 16's record was reviewed on 4/12/23 at 10:31 a.m. Diagnoses included, but were not limited to, senile degeneration of the brain, heart failure, depression, and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was severely cognitively impaired. The March 2023 Physician's Order Summary (POS) indicated orders for the following: - Amlodipine besylate (blood pressure medication) tablet 5 milligram (mg) one time daily - Cholecalciferol (vitamin D3 supplement) tablet 25 microgram (mcg) one time daily - Mirtazapine (antidepressant medication) tablet 15 mg one time daily The March 2023 Medication Administration Record (MAR) indicated the following: - Amlodipine besylate tablet 5 mg was not marked as administered in the morning of 3/22/23, 3/23/23, 3/24/23, 3/27/23, 3/28/23, 3/29/23, and 3/30/23 - Cholecalciferol tablet 25 mcg was not marked as administered in the morning of 3/22/23, 3/23/23, 3/24/23, 3/27/23, 3/28/23, 3/29/23, and 3/30/23 - Mirtazapine tablet 15 mg was not marked as administered in the evening on 3/21/23, 3/22/23, 3/23/23, and 3/29/23 Interview with the Director of Nursing on 4/13/23 at 2:45 p.m., indicated the resident was admitted to the facility on Hospice and they were to provide		**unnecessary drugs** It is the policy of Miller's Health & Rehab La Porte to manage medications appropriately related to administering medications as ordered for unnecessary medications. Resident #16 no longer resides at the facility. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers audited all residents who use outside sources/pharmacies to ensure availability on or before May 5, 2023. All licensed nursing staff and QMA's will be educated on or before May 5, 2023 on the "Medication Administration" policy and procedure (Attachment A). The DON or designee will be responsible to complete the QA tool "Medication QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Medication QA Review" (ATTACHMENT N) specifically	

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	all of her medications. The medications were not delivered to the facility from Hospice in a timely manner. 3.1-48(a)(6)		monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
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 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, interview, and record review, the facility failed to ensure medications were labeled correctly related to eye drops and insulin for 2 of 4 residents observed during	F 0761	**F761 Labe/Store Drugs and Biologicals** It is the policy of Miller's Health & Rehab La Porte to ensure	05/05/2023

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	medication pass (Residents 46 and 167) Findings include: 1. On 4/12/23 at 8:43 a.m., LPN 1 was observed preparing medication for Resident 46. She removed a medication eye drop of Timolol 0.25 mg (milligrams)/ 5 ml (milliliters) ophthalmic solution (eye drop). She administered one drop in each eye to the resident. The medication only had the name of the resident and strength of medication and did not have instructions related to how many drops to give and in which eye(s) . Interview with LPN 1 at that time, indicated the bag with the directions label was missing. The resident was supposed to get 1 drop in each eye. Interview with the Director of Nursing on 4/12/23 11:28 AM., indicated the eye drops should have been properly labeled. 2. On 4/12/23 at 9:18 a.m., LPN 2 was observed preparing medication for Resident 167. The LPN removed a package of insulin from the medication cart. At that time, the label indicated to give 25 units of Glargine insulin at bedtime. LPN 2 administered 20 units of Glargine insulin to the resident. Interview with LPN 2 at that time, indicated the resident was to receive 20 units of the Glargine insulin 2 times a day. A change of direction sticker should have been put on the insulin package. The record for Resident 167 was reviewed on 4/12/23 at 10:00 a.m. The April 2023 Physicians' Order Summary		medications are labeled correctly related to eye drops and insulin. Resident #46 had a new eye drop ordered on 4/12/2023 with delivery on 4/12/2023 with correct labeling for storage. Resident #167 had label updated on 4/12/2023 reflecting change in directions for insulin. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers audited all eye drops and insulins on or before May 5, 2023 ensuring they are labeled correctly including instructions for use. All licensed nursing staff and QMA's were educated on or before May 5, 2023 on the "Medication Labels" policy and procedure (Attachment O). The DON or designee will be responsible to complete the QA tool "Medication QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Medication QA Review"	

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	155297	A. BUILDING 00 B. WING	04/14/2023

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	indicated to administer Insulin Glargine 20 units twice a day. Interview with the Director of Nursing on 4/12/23 11:28 AM., indicated the insulin should have been properly labeled. The facility's "Storage of Medication" policy did not address the updating of labeling. 3.1-25(j) 3.1-25(k)		(ATTACHMENT N) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to an indwelling foley catheter on the floor and improper cleaning of a glucometer for 1 of 1 residents reviewed for catheters and 1 of 1 observations of a glucometer. (Residents 164 and 46) Findings include: 1. On 4/10/23 at 11:03 a.m., Resident 164 was observed sitting in a recliner chair in his room. At that time, his foley (urinary) catheter was hanging on the side of the trash can with the bottom of the bag touching the floor. On 4/11/23 at 9:55 a.m. and at 2:45 p.m., the resident was observed sitting in his recliner chair. The foley catheter was observed hanging on the garbage bag on the side of the trash can. The spout was not tucked inside and was touching the floor, as was the bottom of the bag. On 4/12/23 at 11:20 a.m., the resident was observed sitting in his chair with visitors in the room. The foley catheter was hanging on the side of the trash can. The spout was not tucked inside and was touching the floor, as was the bottom of the bag. The record for Resident 164 was reviewed on 4/11/23 at 2:10 p.m. The resident was readmitted to the facility on 3/23/23. Diagnoses included, but were not limited to, necrotizing fasciitis, chronic	F 0880	**F880 Infection Prevention & Control** It is the policy of Miller's Health & Rehab La Porte to ensure infection control guidelines are in place and implemented related to indwelling foley catheters and cleaning of glucometers. Resident #164 had his care plan updated to reflect the use of the foley catheter on 4/13/2023. Resident #164 had his foley catheter placed in a dignity bag to ensure it was not touching the floor on 4/13/2023. Resident #46 had no ill effects as a result of lack of cleaning the glucometer properly on 4/12/2023. LPN #1 was immediately educated on cleaning of the glucometer on 4/12/2023. All residents residing in the facility have the potential to be affected by the deficient practice. All residents with foley catheters were audited to ensure catheter orders are in place on or before May 5, 2023. LPN #1 was immediately educated on cleaning of the glucometer on 4/12/2023 including return demonstration with cleaning of the glucometer. All nursing staff were educated on or before May 5, 2023 on the	05/05/2023

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	pain, cellulitis of the upper limb, neuromuscular of the bladder, prostate and stomach cancer. The Admission Minimum Data Set (MDS) assessment, dated 3/30/23, indicated the resident was cognitively intact and had an indwelling foley catheter. The resident was an extensive assist with a 2 person physical assist for bed mobility and transfers. There was no Care Plan for the foley catheter. Physician's Order, dated 3/30/23, indicated catheter care every shift and ensure catheter drainage bag was below the waist and covered. The resident had no history of urinary tract infections. Interview with the Director of Nursing (DON) on 4/13/23 at 10:15 a.m., indicated the foley catheter should not be on the floor. The current 8/30/2007, "Foley Catheter Care and Maintenance" policy, provided by the DON on 4/13/23 at 11:40 a.m., indicated ensure the bag or tubing was not touching the floor. 2. On 4/12/23 at 8:43 a.m., LPN 1 was observed preparing to check Resident 46's blood sugar. She removed a glucometer, lancet, alcohol swabs, and the test strips from the medication cart. She performed hand hygiene and donned gloves and proceeded to walk into the resident's room and check her blood sugar. Once the procedure was completed, she put the lancet in the sharps container, removed her gloves, performed hand hygiene, wiped the glucometer with an alcohol pad and placed it back into the medication cart. She did not clean the glucometer before use.		"Foley Catheter Care & Maintenance" policy and procedure (Attachment O). All licensed nurses and QMA's were educated on or before May 5, 2023 on the "Cleaning of the Glucometer" policy and procedure including return demonstration with cleaning of the glucometer (Attachment P). The DON or designee will be responsible to complete the QA tool "Infection QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Infection QA Review" (ATTACHMENT Q) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	Interview with LPN 1 on 4/12/23 at 8:47 a.m., indicated she forgot to clean the glucometer before use, and she usually used alcohol pads to clean the glucometer. She indicated there were disinfecting wipes in the cart called Microdot Wipe Minute. She then used the wipes to clean the meter, and put the meter back in the cart. The manufacturer's instructions on the cleaning wiped indicated the meter must remain wet for 1 minute, LPN 1 indicated she didn't know how to make sure the meter remained wet for 1 minute. The glucometer was used for four residents on the hallway. Interview with the Director of Nursing (DON) on 4/12/23 at 11:28 a.m., indicated LPN 1 should have used the disinfectant wipes correctly before and after use. A Policy, titled, "Cleaning of Glucometer," presented by the DON as current on 4/14/23, indicated: " 1. Purpose: To maintain infection control between resident use. 2. Procedure: A.) The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe (Clorox, Lysol, Gulf South, etc) and completely wiping down the glucometer so it is visibly wet. Avoid getting the screen wet, as the disinfectant could leak into the internal components and destroy the meter. B.) Disinfectant should never be sprayed directly on the machine. Always use a cloth or wipes. C.) Follow manufacturer's instructions related to length of time to disinfect before reusing. Air dry time is typically around 30 seconds, so you must rewet the meter or wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the			

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	manufacturer. D.) Place wrapped Glucometer in covered container and set timer for manufacturer's contact kill time. E.) Once contact kill time has expired, wait and allow to air dry before re-using the glucometer." 3.1-18(b)			