STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 00 B. WING	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 16, 17, 20, 21 and 22, 2023 Facility number: 000140 Provider number: 155235 AIM number: 100266960 Census Bed Type: SNF/NF: 68 NF: 13 Total: 81 Census Payor Type: Medicare: 12 Medicaid: 54 Other: 15 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 1, 2023.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure all residents received their food on the same type of dinnerware for 2 of 3 units reviewed for dining. (The third floor and the dementia unit) Finding includes: During an observation, on 2/16/23 at 12:00 p.m.,	F 0550	**F-550 Resident Rights** It is the policy of Miller's Merry Manor to ensure all resident dignity is maintained. 1. Facility immediately implemented practices to serve all residents on same dinnerware.	03/20/2023

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	the third-floor dining room food was served in white Styrofoam containers and the drinks were in Styrofoam cups. During an interview, on 2/16/23 at 12:03 p.m., the CNA indicated the residents used to get their food served in regular plates and cups. During an observation, on 12/16/23 at 12:23 p.m., the residents in the first-floor dining room were served their food on regular ceramic plates, bowls, and cups. During an observation, on 2/16/23 at 12:29 p.m., on the dementia unit, all the residents had received their food in Styrofoam containers and Styrofoam cups. QMA 2 did not know why the residents' food was served in Styrofoam. During an interview, on 2/22/23 at 5:35 p.m., an anonymous family member indicated their family member received meals in Styrofoam containers a lot. The resident resided on the third floor. During an interview, on 2/16/23 at 12:35 p.m., the Administrator indicated the residents on the first floor received regular plates and cups. The dementia unit and the third-floor residents received their food in Styrofoam containers. The first-floor residents were closer to the kitchen and received regular plates and cups. The residents were not served their meals in the same way. Some of the residents on the dementia unit had problems with eating the Styrofoam cups and they would be served with regular cups. During an interview, on 2/22/23 at 5:35 p.m., the Administrator indicated the facility did not have a policy on dining services.		2. All residents have the potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur all dietary staff will be in-serviced on the policy titled, Resident Dignity, Attachment A. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the SS/Designee will complete the QA Tool titled Annual 2-22-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 3-20-2023	

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	A current policy, titled "Resident's Rights," dated 5/31/2006 and received from the Administrator on 2/22/23 at 4:55 p.m., indicated "...Rights are both human privileges and legal protection. Residents have the legal rights of all United States citizens. Resident also have rights relating to their everyday lives and care in a nursing facility. A facility must inform residents of their rights and post the 'Residents Bill of Rights' in writing in the facility...." 3.1-3(t)			
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on interview and record review, the facility failed to ensure residents who received	F 0552	**F-552 Right to be Informed/Make Treatment**	03/20/2023

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	psychotropic medications had the benefits and risks reviewed with them and their representatives for 2 of 5 residents reviewed for psychotropic medications. (Resident 76 and 69) Findings include: 1. The record for Resident 76 was reviewed on 2/21/23 at 3:42 p.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, delusional disorders, metabolic encephalopathy, and major depressive disorder. A physician's order, dated 9/15/22, indicated to give Risperdal (an antipsychotic) 1 mg (milligram) daily. 2. The record for Resident 69 was reviewed on 2/21/23 at 4:56 p.m. Diagnoses included, but were not limited to, unspecified dementia with mood disturbance, major depressive disorder, hallucinations, delusional disorder, and anxiety disorder. A physician's order, indicated to give Risperdal 1 mg every evening for delusions, dated 10/28//22 and open ended. During an interview, on 2/21/23 at 2:26 p.m., the Clinical Support Nurse indicated the facility did not have any type of consent or documentation where the residents' and representatives were informed of the risks and the benefits of medications which were a high risk. The Nursing Drug Handbook 2023 indicated Risperdal had a black box alert which included there was an increased risk of mortality in elderly patients with dementia-related psychosis, mainly		**Decisions** It is the policy of Miller's Merry Manor to ensure all Residents/Resident Representatives are informed of the risks/benefits of psychotropic medications. 1. Residents identified responsible representative were provided the information of the medications black box warning risk/benefit and a consent to sign, attachment C. 2. All residents that have orders for psychoactive medications with black box warnings for elderly have the potential to be affected by the same deficient practice. All residents affected will have been provided a consent titled, Informed Consent for Use of Psychoactive Medications, attachment C . 3. To ensure that the deficient practice does not recur All Nurses and SSD will be in-serviced on the policy titled Informed Consent for Use of Psychoactive Medications Policy, Attachment D. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled Annual 2-22-23	

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	due to pneumonia and heart failure. The side effects included, but were not limited to, agitation, anxiety, insomnia, headache, aggressive behavior, and orthostatic hypotension. The adverse effects included, but were not limited to, tardive dyskinesia [characterized by tongue protruding, puffing of the cheeks, chewing, or puckering of mouth], muscle rigidity, altered mental status, irregular pulse or blood pressure, cardiac arrhythmias, acute renal failure, hyperglycemia, and death. A current policy, titled "Psychotropic Medication Use," dated 2/18/2019 and received from the Director of Nursing on 2/22/23 at 3:20 p.m., indicated "...Psychotropic medications will only be used when medically indicated to treat a specific condition...Ongoing monitoring will be in place to assess risks vs benefits of continued medication use and psychotropic medications will not be used as a restraint...." A current policy, titled "Resident's Rights," dated 5/31/2016 and received from the Administrator on 2/22/23 at 4:55 p.m., indicated "...The resident has the right to information...right to be informed of total health status in a language they can understand...The resident has the right to choose. The resident has the right to refuse treatment..." 3.1-3(n)(2) 3.1-4(c) 3.1-4(d)		POC (Attachment B). This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 3-20-2023.	
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			

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	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, interview and record review, the facility failed to ensure bilateral cushioned boots were worn and a pillow was placed between a resident's knees with pressure ulcers as ordered by the physician for 1 of 3 residents reviewed for pressure wounds. (Resident 18) Finding includes: During an observation, on 2/20/23 at 2:15 p.m., Resident 18 was lying in bed on his right side with three blankets covering his legs. The resident was not wearing bilateral cushioned boots or had a pillow between his knees. During an observation, on 2/21/23 at 4:24 p.m., the resident was sitting in his wheelchair in the dining room. The resident was not wearing the bilateral cushioned boots and did not have a pillow between his knees. The record for Resident 18 was reviewed on 2/20/23 at 1:50 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, contractures of the muscle in the lower legs, open wound on the left foot, congestive heart failure, major depressive disorder, cognitive communication	F 0686	**F-686 Treatment/Services to Prevent/Heal Pressures Ulcers** It is the policy of Miller's Merry Manor to provide all residents with pressure injuries treatments that are recommended by the NPIAP (National Pressure Injury Advisory Panel) in accordance with physician's orders. 1. Resident identified was immediately provided boots and pillow per plan of care. 1. All residents have the potential to be affected by the same deficient practice. No other residents were affected by this deficient practice. 3. To ensure that the deficient practice does not recur all nursing staff will be in-serviced on the policy titled Pressure Ulcer Treatment, Attachment F.	03/20/2023

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	deficit, and peripheral vascular disease. A physician's order, dated 9/2/22, indicated to always wear cushioned protective boots to both feet. A physician's order, dated 9/2/22, indicated to always keep a pillow between the knees. A care plan, dated 1/15/20, indicated the resident needed extensive assistance with transfers due to contractures of the bilateral legs. Interventions included, but were not limited to, assess for increase in mobility level and/or decrease in mobility level. A care plan, dated 10/5/22, indicated the resident was at risk for complication from a pressure lesion. Interventions included, but were not limited to, administer treatment as ordered, monitor for complaints of pain or discomfort, resident visits the wound clinic weekly. A care plan, dated 12/20/22, indicated the resident developed an abrasion/pressure injury to his right knee related to contractures of the bilateral legs and the inability to reposition self in bed. Interventions included, but were not limited to, treatment as ordered, monitor pain and discomfort, resident would visit wound clinic weekly, staff would anticipate resident's need for comfort and pressure relief, maintain pressure relief to bony prominence's, staff would reposition every 2 hours while in bed, ensure positioning devices are in proper placement. During an interview, on 2/21/23 at 4:24 p.m., the wound care nurse indicated the resident should be wearing the bilateral cushioned boots and had a pillow placed between his knees. She did not		4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled Annual 2-22-23 POC (Attachment B). This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 3-20-2023.	

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	know why the resident did not have them on. A current policy, titled "Pressure Injury Treatment," dated 1/16/20 and received from Administrator on 2/23/23 at 4:55 p.m., indicated "...to provide all residents with pressure injuries treatment that are recommended by the NPIAP (National Pressure Injury Advisory Panel) in accordance with physician's orders. PROCEDURE: All pressure injuries will be assessed using the Staging System which is based upon tissue loss...Use support surfaces such as low air loss mattresses...Continue to turn and reposition the resident regardless of the support system in place. Inspect the skin for additional damage each time turned...Heels with stage 1 or 2 pressure injuries should have heels "floated" by placing a pillow under the legs so the heels are up off the bed, or by using pressure reducing devices with heel suspension. Sold fabric, sheepskin or padded heel protectors with no heel suspension should not be used...." 3.1-40(a)(2)			
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			

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	resident, the facility must ensure that--- §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 interview and record review, the facility failed to identify the resident specific delusions, the distress the delusions caused and any non-easily redirected behaviors for residents prescribed antipsychotics for their delusions for 2	F 0758	**F- 758 Free from Unnecessary Psychotropic Meds/PRN use** It is the policy of Miller's Merry Manor to monitor resident specific	03/20/2023

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	of 5 residents reviewed for psychotropic medications. (Resident 69 and 76) Findings include: 1. The record for Resident 69 was reviewed on 2/21/23 at 4:56 p.m. Diagnoses included, but were not limited to, unspecified dementia with mood disturbance, major depressive disorder, hallucinations, delusional disorder, and anxiety disorder. A care plan, dated 2/12/21, indicated the resident displayed inappropriate physical behavioral issues as exhibited by banging on doors, walls, and furniture, threatening others, and distressful delusion. The interventions included, but were not limited to, administer psychotropic medications as ordered and to document distressful delusions. The care plan did not indicate the resident specific distressful delusions. A PASARR (preadmission screening and resident review), dated 3/8/21, indicated the resident had a dementia exclusion. There were not recent or current mental health symptoms. The primary medical condition for the requiring nursing facility care was dementia. A quarterly behavior/psychotropic medication review, dated 11/10/22, indicated the resident received Risperdal at bedtime. The resident had distressful delusions. The resident was easily redirected from distressing recollection by 1-1 attention and enjoyed talking about past life events. The resident had only isolated episodes of behavioral elevation. There was no contraindication to reducing the medication.		target behaviors related to antipsychotic medication orders. 1. Identified residents behavior trackers were updated with resident specific behaviors. 2. All residents have the potential to be affected by the same deficient practice. An audit was completed on all residents with antipsychotic med orders to ensure resident specific behaviors are included in monitoring. 3. To ensure that the deficient practice does not recur SSD in-serviced on the policy titled Psychotropic Medication Use, Attachment G. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled Annual 2-22-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be	

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	The quarterly review did not include the resident specific distressing delusions or hallucinations. A physician's order, indicated to give Risperdal (an antipsychotic) 1 mg (milligram) every evening for delusions, dated 10/28//22 and open ended. A psychiatric progress note, dated 1/10/23, indicated the resident was seen for dementia, anxiety, insomnia, delusions, and hallucinations. The resident had no current delusions. The staff reported no acute psychiatric concerns at this time. The psychiatric progress note did not include the resident specific delusions. During an interview, on 2/22/23 at 4:46 p.m., the DON (Director of Nursing) indicated the only documentation of the resident delusions was in the care plan. The care plan did not indicate the resident specific delusions or what was distressing to the resident about the delusions. The DON would talk to the nurse on the dementia unit. During an interview, on 2/22/23 at 4:54 p.m., the DON indicated the documentation did not include a description of the resident specific delusions or how they were distressing to the resident. 2. The record for Resident 76 was reviewed on 2/21/23 at 3:42 p.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, delusional disorders, metabolic encephalopathy, and major depressive disorder. A physician's order, dated 9/15/22, indicated to		reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 3-20-2023.	

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(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
	give Risperdal 1 mg daily. A care plan, dated 9/26/22, indicated the resident had mood issues as exhibited by delusions of grandeur as evidenced by thinking she was a member of the Beatles rock group, and her boyfriend was Eric Clapton. The resident accused staff and residents of wanting her 'man' and was verbally challenging. The interventions included, but were not limited to, administer psychiatric medications as ordered, listen to resident concerns and to document any increase in delusions. A psychiatric progress note, dated 11/28/22, indicated the resident was seen for dementia, delusions, anxiety, and depression. The staff reported the resident believed her boyfriend lived with her in her bedroom. The resident was sitting in her chair during the visit and reported she was fine, had been 'taking care of her man' and he was currently watching TV. The plan was to continue the Risperdal at bedtime for the delusions. The psychiatric progress note did not indicate how the resident was distressed by her delusions. A progress noted, dated 2/22/23 at 8:41 a.m., indicated the night CNA (Certified Nursing Assistant) went in the resident's room to check on her. The resident screamed at the CNA to get out because her husband was in the room. The progress note did not include the intervention used or the effectiveness of the intervention. A psychiatric progress note, dated 1/27/23, indicated the resident reported no feelings of depression or anxiety. The staff reported the			

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	155235	A. BUILDING 00 B. WING	02/22/2023

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	resident continued to suffer from distressing delusions at times. The resident was to continue to take the Risperdal 1 mg for the delusions. The psychiatric progress note did not include how many episodes of delusions, how the delusions were distressing to the resident or if the resident could be easily redirected. An IDT (interdisciplinary team) note, dated 1/30/23 at 8:21 a.m., indicated the resident current medications were reviewed for dose reduction. The IDT determined the resident continued to exhibit distressing delusional episodes and it would not be appropriate to make any medication changes. The note did not include the description of the delusions, how they were distressing to the resident and if the resident was easily redirected or the interventions other than medications utilized. During an interview, on 2/21/23 at 2:27 p.m., with the Clinical Support Nurse and DON, the documentation was reviewed with only one incident of the resident needing redirection due to her delusions and the re-direction was successful. The Clinical Support Nurse and the DON could not locate any further documentation of how the resident was distressed by her delusions. A current policy, titled "Psychotropic Medication," dated 2/18/2019 and received from the DON on 2/22/23 at 3:20 p.m., indicated "...Psychotropic Drug Use...To ensure that medications regimen helps promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative[s] in collaboration			

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	with the attending physician/psychiatrist and facility staff; each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition[s]; non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication...the potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Psychotropic medications will only be used when medically indicated to treat a specific condition...Ongoing monitoring will be in place to assess risks vs[versus] benefits of continued medication use and psychotropic medications will not be used as a restraint...The facility will assure that medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for the psychotropic medication is obtained/received...On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the results...Behavior monitoring: Target behaviors must be clearly identified and monitored. Episodes will be documented in the clinical record as they occur along with the results of the interventions used to reduce the behavior or symptoms...Quarterly review by IDT-to include evaluating and planning for reductions, evaluating non-med interventions and evaluating the effectiveness of the medication to help promote or maintain the highest practicable mental, physical and psychosocial well-being...." 3.1-48(a)(3) 3.1-48(a)(4)			

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F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to ensure there was sufficient dietary staff to provide residents with meals on regular dinnerware instead of disposable dinnerware for 66 of 81 residents observed for dining. (The dementia unit and the third-floor residents) Finding includes: During an observation on the dementia unit, on 02/16/23 at 12:29 p.m., the residents' food was served on Styrofoam plates, Styrofoam cups, and no tablecloths on the tables. QMA (Qualified Medication Aide) 2 indicated she was not sure why they were using Styrofoam plates, but it had been happening for a while. During an interview, on 02/16/23 at 12:35 p.m., the	F 0802	**F-802 Sufficient Dietary Support Personnel** It is the policy of Miller's Merry Manor to ensure all residents are served meals on dinnerware. 1. Facility implemented practices to ensure all residents are served on dinnerware unless their plan of care states otherwise. 2. All residents have the potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur all Dietary	03/20/2023

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	Administrator indicated the facility was down 2 people in dietary including the dishwasher position. The first floor was not getting Styrofoam, because they were closer to the kitchen. The rest of the residents were getting Styrofoam. Some residents on the dementia unit had trouble with eating the Styrofoam cups so they got regular cups. During an interview, on 02/21/23 at 11:01 a.m., the Dietary Manager indicated she was serving meals on Styrofoam due to having 3-4 employees quit at the same time and she did not have enough employees in the kitchen to get the dishes washed by the next meal. The Maintenance man and Social Service Director did help as much as they could while they were also completing their other duties. During an interview, on 02/21/23 at 11:01 a.m., Cook 3 indicated she was trying to get help all weekend because she was alone and needed assistance to serve the residents. She indicated she did use Styrofoam to serve the residents. During a resident council meeting, on 2/21/23 at 01:30 p.m., the Resident Council President indicated food had been delivered on Styrofoam plates, because they were low on staff in the kitchen. Last night, 2/20/23, the food at the evening meal was served on Styrofoam. There was not a policy for meal service. 3.1-20(h)		staff will be in-serviced on the need to serve all meals on regular dinnerware unless specified on individual meal tickets. Facility has made adjustments to staff schedules and routines to accommodate serving on regular dinnerware. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Annual 2-22-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 3-20-2023.	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp			

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	§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to prepare pureed food based on the recipe for puree diets for 1 of 1 staff member observed preparing pureed diets. (Cook 4) Finding includes: During an observation, on 2/15/23 at 3:52 p.m., Cook 4 was preparing puree foods for the evening meal. She broke 5 bread sticks into a Robo coupe and added milk from the gallon container. She started the Robo coupe and monitored until she felt the consistency was appropriate. She emptied the contents into a container. She then placed lasagna and 3 more broken bread sticks into the clean Robo coupe. She added milk to the Robo coupe from the gallon container. She blended the food and added milk until the consistency was smooth. She emptied the contents into a steam table pan and covered it with aluminum foil. During an interview, on 2/15/23 at 3:54 p.m., Cook 4 indicated she would monitor the breadsticks in the Robo coupe until she felt the consistency was appropriate. She also added the amount of lasagna and bread sticks in the Robo coupe to prepare the 7 residents with puree diet orders. The recipes for the puree meals were in the binder on the counter across from where she was working.	F 0804	**F-804 Nutritive Value/Appear, Palatable/Prefer Temp** It is the policy of Miller's Merry Manor to prepare puree food according to the recipe. 1. Dietary Manager met with the Cook and reviewed puree recipe. 2 All residents have the potential to be affected by the same deficient practice. 1. To ensure that the deficient practice does not recur all Cook Staff will be in-serviced on following puree recipes. 2. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Annual 2-22-23 POC, Attachment B. This tool will be completed 5 times a week for 2	03/20/2023

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	During an interview, on 2/25/23 at 3:55 p.m., the Dietary Manager indicated she had spoken to the cook and understood the cook did not follow the recipe. A recipe, titled "puree vegetable lasagna," indicated the portion of lasagna to be used was 8 servings, 2 teaspoons of chicken base, 2 cups of hot water and 4 slices of wheat bread. The directions were to place the ingredients in the food processor and blend until smooth. Then pour into a small grease steamtable pan, cover, and steam to 165 degrees F. There was no recipe for puree bread sticks. There was no policy for the preparation of puree foods. 3.1-21(a)(1) 3.1-21(a)(2)		weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 3. All systemic changes will be completed by 3-20-2023.	