STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	5544 E STATE BLVD FORT WAYNE, IN 46815

(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. Survey dates: September 23, 24, 25, 26, 27, 28, and 29, 2022. Facility number:000214 Provider number:155321 AIM number:100267240 Census Bed Type: SNF/NF:45 SNF:7 Total:52 Census Payor Type: Medicare:5 Medicaid:40 Other:7 Total:52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 4, 2022	F 0000	We respectfully request consideration for paper compliance for this Plan of Correction due to the low number of deficiencies cited and the low scope and severity associated with the results from this survey. Sincerely, Amanda Duggan, HFA 260-749-9506	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the			

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

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	resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview and record review the facility failed to identify and maintain code status requirements for 3 of 13 residents. (Resident 50, Resident 7, and Resident 27) Findings include:	F 0578	**F 578: Right to Formulate Advanced Directives**: It is the policy of Miller's Merry Manor Fort Wayne that the facility will identify and maintain accurate records for code status for all residents.	10/14/2022

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	1. The record review for Resident 50 began on 09/23/22 at 12:03 P.M. Diagnoses included senile degeneration of brain, dementia, heart disease, and diabetes. Resident 50's physician orders dated 12/02/21 indicated the resident was DNR (Do Not Resitate). In an interview, on 9/26/22 at 9:18 A.M. RN 4, indicated she went to the computer to verify code status. RN 4 indicated Resident 50 was a no code and life saving Cardo Pulmonary Resuscitation (CPR) would not be administered. A Cardiopulmonary Resuscitation Status form, signed by the POA on admission indicated CPR was to be performed. The form was not signed by the physician. RN 4 was unable to comment on why his chart and orders had conflicting code status designations. 2. The record review for Resident 7 began on 09/23/22 at 01:19 P.M. Resident 7's diagnosis included Parkinson's disease, heart disease, depression, and anxiety. Resident 7's orders dated 3/8/22, indicated the resident was a full code. An order for checking placement of Full Code with blue wristband every shift and replace as needed was dated 3/8/22. Resident 7's treatment administration record dated September 2022 indicated the checks were completed twice a day. An observation with RN 4, on 09/26/22 09:30 A.M. in Resident 7's room, observed no bracelet was above the bed, on the wheelchair, on the walker, or on Resident 7.		**Resident 50, Resident 7, and resident 27:** Code status orders have been clarified. Care plans have been updated as needed. Interventions in place to identify code status per policy. All residents have the potential to be affected. Review of all resident code status was completed 9-26-22 and again 10-11-22. Care plans have been reviewed to ensure accuracy. The facility will put into place review of code status for new admissions and for those with code status changes as part of the daily morning meeting M-F (attachment A). All staff educated on the code status policy for the facility on 10-7-22. Agency staff are made aware of code status policy prior to working on the floor. There is a binder in place at the nurse's desk which gives guidance for obtaining code status orders. A QAPI action plan has been initiated to follow this issue (attachment B). To ensure ongoing compliance the DON/Designee will complete the audit tool "POC 2022 Audit Review" (attachment C) daily M-F x 4 weeks then every 2 weeks x 8 weeks then monthly until 100% compliance is maintained for 6 consecutive months. The QAPI action plan be reviewed and revised as needed in the monthly QAPI meeting.	

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	During an interview with RN 4 on 09/26/22 at 10:13 A.M., RN 4 indicated Resident 7's full code status required a blue bracelet as visual reminder of status. She ensured Resident 7 now had a bracelet above the bed as Resident 7 would not leave on their wrist. 3. The record review for Resident 27 began on 9/23/22 at 1:25 P.M. The record indicated resident code status was Do Not Resisuctate (DNR). Resident 27's diagnosis included dementia, heart disease, kidney disease, and diabetes. Resident 27 had an order for DNR dated 1/23/22. Resident 27's Cardiopulmonary Resuscitation Status form was signed by a representative. The form was not signed by the physician. In an interview on 09/26/22 at 09:22 A.M., RN 4 indicated the form was to be signed by both the representative and physician to be valid. A policy titled, "Code Status & Advance Directive Determination" dated 6/17/2019 was provided by DON on 9/27/22 at 7:00 AM. The policy indicated ...CPR status will be reviewed with any re-admission or change per resident request and a new CPR status form will be completed with any change ....After a CPR decision has been made the form signed by resident/family will be placed on the medical record in the appropriate location ... The CPR status form will be signed by the physician on the next visit ...If CPR is to be initiated a blue wristband will be applied to the resident's wrist. If the resident will not physically wear the code blue bracelet, the bracelet will be applied to the head of the bed and on the resident's walker or wheelchair handle ...		Date of compliance: 10-14-22	

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	3.1-4(e)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a			

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	transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information			

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	including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on interview and record review the facility failed complete assessment for transfer documentation for 1 of 2 residents reviewed. (Resident 32) Finding include: A record review for Resident 32 began on 9/23/22 at 12:08 P.M. Diagnosis included dementia, heart disease, diabetes, and abnormal gait. Resident 32's most recent care plan indicated a focus on cognitive impairment related to dementia diagnosis identified on 7/20/21. The care plan also indicated Resident 32 was at risk for falls initiated on 7/1/21. A review of Resident 32's fall history indicated Resident 32 fell on 5/18/22 and returned from emergency room on the same date. Resident 32's progress notes indicated on 5/18/22 at 9:33AM a nurse noted resident was sent to ER for evaluation and treatment of change of consciousness. The nurse indicated Resident 32 fell during the night with injuries to the head and face. The note indicated Resident 32 was also having some shortness of breath and swelling with recent weight gain.	F 0622	**F 622: Transfer/Discharge**: It is the policy of Miller's Merry Manor Fort Wayne that the facility will complete a transfer assessment for all resident's requiring transfer to another facility to ensure information is provided to enhance continuum of care. **Resident 32:** Resident chart reviewed. Has no other transfers since 5/18/22. All residents transferring out of the facility have the potential to be affected. Reviewed the past 7 days of transfers to ensure that proper assessments were completed 10-11-22. There have been no transfers requiring assessment. The facility will also start reviewing all transfers for proper assessments in the daily morning stand-up. This has been added to the agenda for review (attachment A). All staff educated on the transfer/discharge policy for the facility on 10-7-22. Agency staff have binder available at the nurses	10/14/2022

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	An Occurrence Investigation, provided by the DON (Director of Nursing) on 9/27/22 at 7:00 A.M., indicated Resident 32 had a fall on 5/18/22 at 4:15 AM, with head injury and 15-minute neurological checks were initiated. The neuro checks were every 15min x4 then every 30min x4, then a 2hr check recorded. The next (3) 2hr checks indicated Resident 32 was at the hospital. There were no neurological changes noted on the form. The bottom of the sheet indicated Resident 32 fell at 4:15AM, with emergency services transport at 9:40AM and returned from hospital at 4:00PM. A follow up fall assessment was completed. In an interview on 09/27/22 at 08:53 A.M., the DON indicated Resident 32 was sent out on 5/18/22 not in relation to the fall but rather due to swelling and excessive weight gain. The DON indicated she was unable to locate a nursing transfer to hospital assessment or paperwork. There was no documentation of the transfer to hospital assessment in Resident 32's record. A review progress notes dated 5/18/22 did not indicate the hospital had been informed of residnet status, the reason for transfer or current orders to maintain a continuum of care. The Emergency Department (ED) paperwork, provided by the DON on 9/28/22 at 10:06 A.M., indicated present illness was for evaluation of a fall. It was reported Resident 32 was on blood thinners per medic report, demented, and acting normally. The form indicated while the resident was there the NP (Nurse Practitioner) wanted an evaluation of leg swelling. The resident had with no cough or shortness of breath. The diagnosis indicated on the ED form indicated head concussion.		desk that explains procedure and required paperwork for transfers and discharges. A QAPI action plan has been initiated to follow this issue (attachment D). To ensure ongoing compliance the DON/Designee will complete the audit tool “POC 2022 Audit Review” (attachment C) daily M-F x 4 weeks then every 2 weeks x 8 weeks then monthly until 100% compliance is maintained for 6 consecutive months. The QAPI action plan will be reviewed and revised as needed in the monthly QAPI meeting. Date of compliance: 10-14-22	

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	A policy, titled "Transfer to Hospital" dated 8/13/21, provided by DON on 9/28/22 at 10:06 AM indicated. To provide continuity of care between transferring facility and hospital .... A. Complete and print the Transfer to Hospital Assessment ... ... 3.1-12(4)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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			

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	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 ensure side effects of antidepressant and antipsychotic medications were monitored for 1 of 5 residents reviewed. (Resident 38). Finding included: Resident 23's record review began on 9/26/22 at 2:08 P.M. Diagnosis included, major depressive disorder, recurrent, severe with psychotic symptoms. The most recent MDS (Minimum Data Set) assessment indicaated a BIMS (Brief Interview of Mental Status) score was unable to be completed. A physician order dated 7/26/22 indicated to give Risperdal tablet 0.5 mg (Milligrams) (risperidone) 1 tablet by mouth two times a day for depressive disorder with psychotic features.	F 0758	**F 758 Free from Unnecessary Psychotropic Meds**: It is the policy of Miller's Merry Manor Fort Wayne that the facility will monitor side effects for all residents receiving antipsychotic medications. **Resident 38:** Monitoring for resident's medications was immediately added to the MAR 9-26-22. All residents receiving antipsychotic medications have the potential to be affected. A review of all antipsychotics was completed 9-26-22, to ensure that proper side effect monitoring was in place for all medications. All staff nurses educated on the requirements for monitoring of	10/14/2022

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	There were no physician orders to indicate the side effects of this medication were to be monitored. A physician order dated 8/17/22, indicated to give Sertraline HCL tablet 50 mg, 1 tablet by mouth in the evening for depression. There were no physician orders to indicate the side effects of this medication were being monitoring. A care plan dated 8/8/22, indicated the focus of: the resident displayed inappropriate physical behavioral issues as exhibited by, hitting, kicking, pinching staff during care, hitting staff during care slapping. The goal indicated; the resident would have no adverse side effects from medication through next review. The interventions indicated, black box warning for antipsychotic had been reviewed. Administer psych medication as ordered. Monitor medication side effects at least daily on the psychotropic administration record. A care plan dated 8/8/22, indicated the focus was depression: the resident had potential for signs and symptoms of depression (symptoms include: persistent feelings of sadness or loss of interest changes in sleep, appetite, energy, concentration related to mood) related to: loss of independence, and decline in health. Depressive symptoms for the resident included: irritability. The goal indicated; the resident would have no adverse effects from medication through next review. The interventions indicated to give psych meds as ordered, monitor medication side effects at least daily regarding psychotropic medication side effects at least daily on psychotropic medication record.		antipsychotic medications on 10-7-22. Agency staff have binder available at the nurse's desk that explains procedure for order entry and adding monitoring for antipsychotic medications. A QAPI action plan has been initiated to follow this issue (attachment G). To ensure ongoing compliance the DON/Designee will complete the audit tool "POC 2022 Audit Review" (attachment C) daily M-F x 4 weeks then every 2 weeks x 8 weeks then monthly until 100% compliance is maintained for 6 consecutive months. The QAPI action plan be reviewed and revised as needed in the monthly QAPI meeting. Date of compliance: 10-14-22	

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	A review of the MAR (medication administration record), dated September 2022 indicated Resident 38 received the medication Risperdal 0.5 mg two times a day in the morning and evening on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 ,17, 18,19, 20, 21, 22, 23,24, 25, and 26. There were no indications the side effects of this medication were monitored in the MAR for the month of September 2022. A review of the MAR, dated September 2022. Indicated Resident 38 received the medication Sertraline 50 mg daily in the evening on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 ,17, 18,19, 20, 21, 22, 23,24, 25, and 26. There were no indications the side effects of this medication were monitored in the MAR for the month of September 2022. A review of the MAR, dated August 2022. Indicated Resident 38 received the medication Risperdal 0.5 mg two times a day in the morning and evening on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 ,17, 18,19, 20, 21, 22, 23,24, 25, 26, 27, 28, 29, 30, and 31. There were no indications the side effects of this medication were monitored in the MAR for the month of August 2022. Review of the MAR, dated August 2022. Indicated Resident 38 received the medication Sertraline 50 mg daily in the evening on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 ,17, 18,19, 20, 21, 22, 23,24, 25, 26, 27, 28, 29, 30, and 31. There were no indications the side effects of this			

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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
	medication were monitored in the MAR for the month of August 2022. In an interview on 9/26/22 at 2:40 P.M., the Director of Nursing indicated there should be a physician order to monitor side effects. A current facility policy, Psychotropic medication use, was provided by the Director of Nursing on 9/27/22 at 7:00 AM. The policy indicated ..." Drug Antipsychotic medications, side effects monitoring: monitor daily on Med Admin Record (MAR) ...Drug Antidepressant Medication, side effects monitoring: Monitor daily on psych med admin record ....." 3.1-48(b)			
F 0867 SS=E Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on observation, interview, and record review the facility failed to ensure compliance on prior identified advance directive citation. The facility failed to ensure complete records of quality assurance efforts for 4 of 12 months regarding advance directives. (May 2022, June 2022, July 2022, and August 2022) Findings include: The facility annual survey completed on 7/23/2021 identified noncompliance regarding advance	F 0867	**F 867 QAPI/QAA**: It is the policy of Miller's Merry Manor Fort Wayne that the QAPI committee will develop and implement appropriate action plans to correct identified deficiencies. There is potential for all resident's to be affected by noted deficiencies if appropriate action plans are not implemented and followed. There have been no noted adverse effects noted to	10/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 00 B. WING	09/29/2022

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	directives. The facility was found to be noncompliant regarding advance directives on 9/30/22. Reference F578 In an interview with DON on 09/29/22 at 10:30 AM the DON indicated she did audits, staff training, and chart reviews after the last annua survey. The DON indicated she no longer found errors therefore focused on other areas of concern, so there were no quality assurance efforts to follow up with advance directive concerns during the months of May, June, July, and August 2022. There was no policy and procedure provided prior to exit regarding quality assurance. 3.1-52		residents. New action plans have been initiated for all deficiencies cited in the annual survey. These will be followed by the QAPI committee in the monthly QAPI meeting for a minimum of six months. The committee will determine when the issue is resolved. Follow up review of the action plan will be determined at that time by the committee. A QAPI action plan has been initiated to follow this issue (attachment E). To ensure ongoing compliance the ADM/Designee will complete the audit tool “QAPI 2022 Review” (attachment F) monthly until 100% compliance is maintained for 6 consecutive months. The QAPI action plan be reviewed and revised as needed in the monthly QAPI meeting. Date of compliance: 10-14-22	