STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. BUILDING 00 B. WING	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

(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: October 31, 2024 and November 1, 4, 6, and 7, 2024 Facility number: 000089 Provider number: 155173 AIM number: 100276660 Census Bed Type: SNF/NF: 68 SNF: 5 Total: 73 Census Payor Type: Medicaid: 59 Other: 14 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 15, 2024.	F 0000	November 28, 2024 Indiana State Department of Health Division of Long-Term Care, Section 4 B 2 North Meridian Street Indianapolis, Indiana 46204 To Whom it May Concern: A Recertification and State Licensure Survey was conducted at Miller's Merry Manor of Marion on November 7, 2024. Please find the enclosed Plan of Correction being submitted as remedies to the deficiencies that were found during our survey. All systemic changes and education were completed on or before November 29 , 2024. With regards to our Plan of Correction from the November 7, 2024 C Survey we hope that you will find our remedies both sufficient and thoroughly explained in providing a clear picture of how we corrected these concerns. We respectfully request *paper compliance* for this plan of correction for this F Tags. All areas have been corrected, none of which were actual harm to any residents. We will continue to abide by our plan of correction as indicated, and will continue to monitor,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	11/29/2024

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			through audits and correct any future areas of concern per our plan of correction. If you have any questions or require additional information, please contact me at 765 662 3981 Thank you. Sincerely, Paula Juday, HFA, LMSW	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure a resident's urinary catheter was handled in a manner to support the resident's dignity when the drainage bag was left in the view of sight of others within the facility. (Resident 68) Findings include: During an observation on 11/1/24 at 10:11 a.m., Resident 68's was in bed, with the catheter bag hanging on the right side of the bed frame. The bag was exposed and urine could be seen in the bag. During an observation on 11/6/24 at 9:47 a.m., the resident was in bed, with the urinary catheter bag hanging on the right side of the bed frame. The bag was exposed and urine could be seen in the bag. Resident 68's clinical record was reviewed on 11/6/24 at 10:50 a.m. Physician orders, dated 5/15/24, indicated catheter care should be performed every shift. The catheter drainage bag was to be below the waist and covered every	F 0550	**F 550 Resident Rights / Exercise of Rights** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to *Place catheter bag in a catheter cover bag underneath wheelchair or on side of bed.* (Attachment 1-A) *Catheter cover bag for resident 68 was placed on both sides of his bed in order for the catheter bag to be placed in a catheter cover bag at all times while resident was in bed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility with catheters had the potential to	11/22/2024

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	shift. During a catheter care observation on 11/7/24 at 10:16 a.m., RN 3 indicated there was a device on the left side of the resident's bed, on the railing, which contained the catheter bag and served as a covering for the bag. The left side of the bed was against the wall. The RN was not sure why a similar device was not in place on the right side of the bed. The right side of the bed was visible to the rest of the room and from the hallway. A current facility policy, titled "Foley Catheter Care & Maintenance," provided by the Administrator on 11/7/24 at 10:40 a.m., indicated the following: Placement of Catheter Tubing Procedure: 1) When in bed or wheel chair...b)Place in a catheter cover bag underneath wheelchair or on side of bed.... During an interview with the Infection Preventionist on 11/7/24 at 11:18 a.m., they indicated all catheter bags should be placed in dignity bags when residents are both in or out of their room(s). 3.1-3(a)		be affected by the alleged deficient practice. *100% audit completed of all residents with catheters to ensure that all residents with catheters have a catheter cover bag on their wheelchair and on both sides of their bed. No other residents were identified to have a catheter not in a catheter cover or to be affected by this deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** *All nursing staff were educated regarding policy and procedure of Foley Catheter Care & Maintenance, including *To Place catheter bag in a catheter cover bag underneath wheelchair or on side of bed.* (Attachment 1-A). In Service education was completed on 11/20/2024. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct Quality Assurance Audit using the QA Tool “URINARY CATHETER REVIEW” (Attachment 1-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 8 weeks, and monthly X2, and quarterly X1. This will be reviewed in the facility Quality	

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			Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 12 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool "URINARY CATHETER REVIEW."	
F 0808 SS=D Bldg. 00	483.60(e)(1)(2) Therapeutic Diet Prescribed by Physician Based on observation, interview, and record review, the facility failed to serve a therapeutic pureed diet as ordered by a physician for 2 of 2 residents reviewed who received pureed diets (Residents 42 and 43). Findings include: During a lunch meal observation on 11/4/24 from 11:20 a.m. to 11:47 a.m., a "regular" gelatin dessert with whipped topping was served to Residents 42 and 43. The gelatin was cubed in shape and topped with whipped cream. The cubes were solid pieces of gelatin. Both Residents 42 and 43 consumed a portion of the regular gelatin. During an observation on 11/4/24 at 11:50 a.m., Resident 43's meal ticket indicated "gravy to meat and potatoes." Resident 43's meat and potatoes contained no gravy, nor was there gravy provided for a staff member to use for topping the food. A current facility lunch meal, portion size and texture serving guide (also known as a spread sheet), dated 11/4/24 and provided by the Administrator on 11/7/24 at 10:50 a.m., indicated	F 0808	**F 808 Therapeutic Diet Prescribed by Physician** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to *Serve food by following the therapeutic diet spreadsheet* according to the Policy and Procedure titled "Food Production Service" (Attachment 2-A) * The diet and menu card of both residents 42 and 43 were reviewed and identified as accurate * The production sheet for the meal service on 11/4/2024 was reviewed and identified to be accurate. * The dietary manager and cook were educated on the importance of serving food following the therapeutic diet spreadsheet. This was done on 11/4/2024.	11/22/2024

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	residents who had pureed diet orders were menued to receive a 1/2 (#8 scoop) of pureed gelatin topped with whipped topping. The current facility recipe for pureed diet gelatin, dated 11/4/24 and provided by the Dietary Manager on 11/4/24 at 12:03 p.m., indicated cubed gelatin was to be placed in a blender or food processor and blended until smooth, then topped with whipped topping. The recipe for gelatin contained a standard package of gelatin and hot water. During an interview on 1/4/24 at 11:51 a.m., QMA 6 indicated she was not aware of Resident 43's menu card directing the use of gravy on meat and potatoes. During an interview, 11/04/24 at 12:06 p.m., QMA 6 indicated the dietary department never provided gravy. During the meal, the resident had eaten both items without gravy. During an interview on 11/4/24 at 12:04 p.m., the Dietary Manager indicated she had not realized the gelatin was menued to be pureed prior to service. 1. Resident 42's clinical record was reviewed on 11/04/24 at 2:18 p.m. Current diagnoses included vascular dementia, anxiety, and dysphasia-oropharyngeal phase. The resident had a current order for a pureed diet, dated 7/9/24. The resident had a current care plan problem/need regarding, nutritional risk due to related to a therapeutic diet, mechanically altered diet, a diagnosis of dysphasia, and a history of weight loss. This care plan problem originated 1/19/24. An approach to this problem was to serve a diet		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility with a therapeutic diet had the potential to be affected by the alleged deficient practice. *100% audit completed of all residents with therapeutic pureed diets to ensure that all residents with therapeutic pureed diets have diet noted on their menu card. No other residents were affected by this deficient practice. *All dietary and nursing staff were educated regarding the need to follow the policy and procedure to produce and serve food according to the therapeutic diet of each individual resident to ensure residents are all receiving the appropriate diet. In-service education completed on 11/20/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** *All dietary and nursing staff were educated regarding policy and procedure of Food Production Service, including *To Serve food by following the therapeutic diet spreadsheet* (Attachment 2-A). In Service education was completed on 11/20/2024.	

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	as ordered, dated 1/31/20. The resident's most recent speech therapy note for services from the period of 7/3/24 to 7/15/24 indicated the resident required a pureed diet due to a diagnosis of dysphasia. 2. Resident 43's clinical record was reviewed on 11/04/24 at 3:20 p.m. Current diagnoses included dementia, depression, and anxiety. The resident had a current order for a pureed diet served with extra butter, sauce, gravy for potatoes and meats, dated 1/15/24. The resident had a current care plan problem/need regarding, nutritional risk related to: mechanically altered diet, end stage illness/condition, and on hospice care, dated 2019. An approach to this problem/need was diet is served as ordered. The resident's most recent speech therapy note for services from the period of 1/15/24 to 1/29/24 indicated the resident required a pureed diet due to a diagnosis of dysphasia. The resident received treatment due to pneumonia related to inhalation of food and vomiting. A current, 11/23/2011, policy titled, "Dietary Manual- Subject -Food Production Services," provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following: 2. Food is chopped, cut, ground and pureed to meet individual resident needs. Procedures to alter food texture are listed on the recipes...4. Food is served by following the therapeutic diet spreadsheets and is portioned by weighing and by using the correct serving utensils... A current, undated, facility policy titled, "Diets Available In This Facility,"provided by the		**How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct a Quality Assurance Audit using the QA Tool “DIETARY SERVICES REVIEW” (Attachment 2-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 8 weeks, monthly X2, and quarterly X1. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 12 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool “DIETARY SERVICES REVIEW.”	

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	Administrator on 11/7/24 at 10:50 a.m., indicated the following: Pureed, Regular diet with food pureed to a smooth pudding-like consistency. For those who have considerable problems chewing or swallowing... 3.1-21(b)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was served under sanitary methods regarding food handling, hand washing, and glove use. This deficient practice had the potential to impact 73 of 73 residents who received meals in the facility. Findings include: 1. A completed "Roster Matrix" form, provided by the facility on 10/30/24 following the entrance conference, indicated the facility had no residents who received nutrition by any alternate means other than oral eating. During a lunch meal service observation on 11/4/23 from 11:40 a.m. to 12:03 p.m., the following concerns regarding sanitary food preparation and distribution were made: Cook 5 wore gloves. She touched the outside of meal trays, thermal plate bases, heated tray pallets, bread bags, bread rolls, and cheese with her gloved hands. She did not change her gloved hands as she touched the various items. She used her solid gloved hands to open the bread rolls and placed cheese slices inside the roll. Using the same gloved hands, she handed the prepped roll to Cook 4, who took the roll with her	F 0812	**F 812 Food Procurement, Store / Prepare/ Serve – Sanitary Conditions** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor that all foods shall be prepared and served in a clean, sanitary, and safe manner. (Attachment 3-A) *This deficient practice had the potential to impact all residents, but had no negative impact on any residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility had the potential to be affected by the alleged deficient practice. No residents were affected by this deficient practice.	11/22/2024

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	gloved hands. Cook 5 did not change her gloves during this process. Cook 4 received prepared bread rolls and cheese with her gloved hands. She used her gloved hands and touched meal tickets, trays, plates, thermal bases. thermal lids, heated pallets, countertops, bread bags, bread rolls, and cheese. At no time during the meal service did she change her soiled gloves. Cook 5 left the kitchen wearing her soiled gloves. As she returned to the kitchen, she touched the door and the door knob. She was no longer wearing gloves. She took gloves from the glove box and placed said gloves on her hands. She did not wash her hands prior to applying the gloves. 2. During a dining observation of the memory care unit, on 11/4/24 at 12:00 p.m., residents were being served Philly cheese steak sandwiches on buns. At approximately 12:11 p.m., CNA 4 was observed taking trays from the food cart and delivering them to residents already seated at dining tables. The CNA delivered three trays to various residents. For each of the three residents, the CNA was observed to uncover their plates, offer ketchup to each, then proceeded to open the ketchup packets and squeeze the contents onto each resident's sandwich. The next resident to be served asked the CNA to cut the sandwich. The CNA proceeded to place her bare left hand on the bun, gripped it to secure it, and then used the resident's knife to cut the sandwich into halves. The CNA did not complete hand hygiene during the observation. During an interview on 11/4/24 at 12:03 p.m., the Dietary Manager indicated food should not be		*Dietary manager immediately educated the cooks present during the meal service on 11/4/2024 on the policy and procedure “Food Preparation, Food Handling, and Service” (Attachment 3-A) and then conducted a formal In-service with all dietary staff regarding the policy “Food Preparation, Food Handling, and Service (Attachment 3-A). In Service completed 11/20/2024. *All nursing staff were educated regarding the policy and procedure “Food, Preparation, Food Handling, and Service” (Attachment 3-A). In Service completed 11/20/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** *Dietary manager immediately educated the cooks present during the meal service on 11/4/2024 on the policy and procedure “Food Preparation, Food Handling, and Service” (Attachment 3-A) and then conducted a formal In-service with all dietary staff regarding the policy “Food Preparation, Food Handling, and Service (Attachment 3-A). In Service completed 11/20/2024. *All nursing staff were educated regarding the policy and procedure “Food, Preparation, Food Handling, and Service”	

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	touched with gloved hands and hands should be washed before gloves were applied. A current, 10/6/15, policy titled "Dietary Manual: Subject: Hand Washing," provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following...It is policy that all dietary employees know and understand when hand washing is required and how to properly wash their hands...F) After handling soiled surfaces, equipment or utensils...G) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.... A current 9/9/15, facility policy titled, "Dietary Manual: Subject: Glove Policy," provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following: ...It is the policy that gloves use will be limited use glove and will be used for only one task. Hands will be properly washed before and after glove use...Procedure: 1) a. Whenever possible use utensils such as tongs, spoons and spatula instead of gloves to avoid getting the false sense of security with the gloves and over using gloves.....4) d. If using gloves, hands must be properly washed before and after glove use...When making bread and butter and a new loaf needs to be opened, gloves must be removed, hands properly washed. Open new loaf of bread, then properly wash hands and don a new pair of gloves. 3.1-21(i)(1)		(Attachment 3-A). In Service completed 11/20/2024. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct Quality Assurance Audit using the QA Tool "Quality Assessment / Improvement Program DIETARY SERVICES REVIEW" (Attachment 2-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 8 weeks, monthly X2, and quarterly X1. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 12 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool "DIETARY SERVICES REVIEW."	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control A. Based on observation, interview, and record review, the facility failed to ensure Enhanced	F 0880	**F 880 Infection Prevention & Control**	11/22/2024

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	Barrier Precautions (EBP) were followed according to facility policy and physician orders during wound care for 1 of 1 residents reviewed for wounds. (Resident 23) B. Based on observation and interview, the facility failed to ensure staff administered medications in a sanitary manner for 1 of 2 residents observed for medication administration. (Resident 20) Findings include: A. Resident 23's clinical record was reviewed on 11/6/24 at 3:02 p.m. Diagnoses included acute diastolic (congestive) heart failure, (other) abnormalities of gait and mobility, Type 2 diabetes mellitus with diabetic neuropathy, morbid (severe) obesity due to excess calories, unspecified fracture of left femur, and difficulty in walking. Current physician orders included (9/9/24) apply povidone iodine to left heel every shift for wound care, (6/7/24) skin protectant to right heel for skin protection, and (6/4/24) EBP during high-contact resident care. A current care plan, dated 6/4/24, indicated the resident required EBP during high-contact care due to antibiotic resistant bacteria in their urine and current wounds. Personal protective equipment (PPE) was to be accessible for use. A sign was to be placed on the door of the resident's room to communicate EBP to staff and visitors. During a review of progress notes on 11/7/24 at 9:36 a.m., a note from 11/4/24 at 11:01 am. indicated the pressure injury had a length of 1.0 centimeter (cm) and a width of 1.5 cm.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor for staff to utilize personal protective equipment (PPE) as source control to prevent the spread of MDRO from one resident to another. (Attachment 4-A) *Resident 23 was observed by nursing following the wound care treatment performed on 11/7/2024 with no ill effects noted. *RN 3 was educated on policy titled "Enhanced Precautions for novel and targeted MDRO's" on 11/7/2024 It is the Policy of Miller's Merry Manor for staff to utilize gloves during instilling eye drops. (Attachment 4-B). *Resident 20 was observed by nursing following the administration of eye drops on 11/6/2024 with no ill effects noted. *QMA 7 was educated on the policy titled "Eye Drops and Eye Ointment Procedure" and the need to wear gloves during administration of eye drops 11/7/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**	

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	During an observation on 11/7/24 at 10:05 a.m., RN 3 performed wound care to the left heel for Resident 23. Supplies were brought into the room and the nurse performed hand hygiene, donned gloves, and cleaned the pressure area with soap and water, dried the area, and applied povidone iodine (a topical antiseptic to prevent infections) to the left heel wound. The wound was approximately the size of a quarter and dark red in appearance. The nurse replaced the resident's sheet and blanket and disposed of used supplies at that time. During an interview with RN 3 on 11/7/24 at 10:35 a.m., she indicated a gown was not required for wound care. She was aware of the EBP ordered for the resident. Gowns were required only when performing peri-care (care of the genital area). A current facility policy, dated 4/6/24, titled "Enhanced Precautions for Novel and Targeted MDRO's (multidrug resistant organisms) and provided by the Infection Preventionist on 11/7/24 at 10:10 a.m., indicated the following: "Policy - To prevent the spread of multidrug resistant organisms (MDRO's) from one resident to another resident via health care workers hands and clothing and to protect vulnerable residents. The use of EBP is intended to interrupt the spread of novel or targeted MDRO's . EBP is targeted use of gown and glove use during high contact resident care activities for residents with wounds and indwelling devices...Procedure - Residents with wounds or indwelling devices and residents infected or colonized with an MDRO will be cared for by staff using a gown and gloves during high contact resident care...Examples of high contact resident care include, but are not limited to...8) performing wound care (caring for an opening in the skin...that is long lasting or chronic in nature		*All residents residing in facility wound care treatment and / or eye drops had the potential to be affected by the alleged deficient practice. No residents were negatively affected. *100% audit completed of all residents with treatment orders for wound care were reviewed and signage for PPE was updated on door. *100% audit completed of all residents with eye drop orders and no other residents were negatively affected by deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** *All nursing staff were educated on the policies “Enhanced Precautions for novel and targeted MDRO’s” (Attachment 4-A) and “Eye Drops and Eye Ointment Procedure”. (Attachment 4-B) 11/20/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct a Quality Assurance Audit using the QA Tool “NURSING SERVICES/ INFECTION CONTROL” (Attachment 4-C). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 8	

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	155173	A. BUILDING 00 B. WING	11/07/2024

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	such as pressure ulcers, diabetic wounds, non-healing surgical wounds, and chronic vascular ulcers...." During an interview with the Infection Preventionist on 11/7/24 at 11:28 a.m., the IP indicated wound care required PPE including gloves and gowns for wound care. In the case of Resident 23, the staff should gown and glove during wound care on the left heel. B. During a medication administration observation, on 11/6/24 at 9:22 a.m., Qualified Medication Aide (QMA) 7 prepared and administered oral medications for Resident 20. She then administered lubricant eye drops in each eye by using her bare left hand to lift each eye lid. The QMA did not perform hand hygiene, nor don gloves, before administering the eye drops. During an interview, on 11/6/24 at 9:42 a.m., QMA 7 indicated it was not her practice to don gloves prior to administering eye drops and was unsure if there was a facility policy pertaining to eye drop administration. A current facility policy, titled "Eye Drops and Eye Ointment Procedure," provided by the Administrator on 11/6/24 at 11:16 a.m., indicated "16) Perform hand hygiene and put on gloves...." During an interview at the same time the policy was provided, the Administrator indicated it was the expectation of the facility that QMA 7 should be aware of this policy. 3.1-18(l)		weeks, monthly X2, and quarterly X1. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 12 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool “NURSING SERVICES/ INFECTION CONTROL”	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations			

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	Based on record review and interview, the facility failed to ensure pneumococcal vaccination (to protect against the bacterium Streptococcus pneumoniae) was offered or administered for 3 of 5 residents reviewed for immunizations. (Residents 32, 53, and 14) Findings include: 1. Resident 32's clinical record was reviewed on 11/4/24 at 11:40 a.m. Diagnoses included left-side non-dominant hemiplegia and hemiparesis following cerebrovascular disease, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus. The resident admitted in 2020. Resident 32's immunization record indicated an undated refusal for the pneumococcal 13-valent conjugate vaccine (PCV 13) and pneumococcal polysaccharide vaccine (PPSV 23). A "Pneumococcal/Prevnar 13 Vaccine Consent" form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident had refused the above vaccines on 2/28/20. During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she discussed the importance of vaccines during care plan meetings, but was not able to provide additional documentation for consent or refusal following 2020, including in 2024. 2. Resident 53's clinical record was reviewed on 11/4/24 at 2:17 p.m. Diagnoses included orthopedic aftercare following surgical amputation, heart failure, and diabetes mellitus due to the underlying condition of hyperglycemia. The admission date was 4/19/24.	F 0883	**F 883 INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to administer annual Pneumococcal vaccines. (Attachment 5-A) *Residents 32 and 14 were immediately offered pneumococcal vaccines, provided with education, and both declined. *Resident 53 discharged from facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility had the potential to be affected by the alleged deficient practice. No residents were negatively affected. *100% audit completed of all residents pneumococcal vaccine status were reviewed and any resident that qualified for the vaccine was offered to receive the vaccine. For residents that declined the vaccine, education was provided. Completed 11/29/2024. **What measures will be put into**	11/29/2024

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	Resident 53's immunization record indicated an undated refusal for the Pneumococcal 20-valent conjugate vaccine (Prevnar 20) and a entry marked as pending for the Prevnar 20 vaccination. A "Pneumococcal Vaccine Consent" form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident wished to receive the recommended pneumococcal vaccine based upon vaccination history. During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she was not able to explain the marked refusal or confirm if the resident had received the appropriate vaccination. 3. Resident 14's clinical record was reviewed on 11/6/24 at 11:47 a.m. Diagnoses included Alzheimer's Disease, COPD, and generalized anxiety disorder. The resident admitted in 2019. Resident 14's immunization record indicated an undated refusal for the PCV 13 vaccination. A "Pneumococcal/Prevnar 13 Vaccine Consent" form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident had refused the PCV 13 on 3/25/19. During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she discussed the importance of vaccines during care plan meetings, but was not able to provide additional documentation for consents or refusals in the years following 2019, including 2024. During a follow-up interview, on 11/7/24 at 12:10 p.m., the Infection Preventionist indicated she contacted residents and families yearly, starting in		**place and what systemic changes will be made to ensure that the deficient practice does not recur** *All nursing staff were educated on the policy “Influenza and Pneumococcal Immunization Program” (Attachment 5-A). 11/20/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** The facility will conduct Quality Assurance Audit using the QA Tool “PNUEMOCOCCAL IMMUNIZATION REVIEW” (Attachment 5-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 8 weeks, monthly X2, and quarterly X1. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will also utilize the Quality Assurance Audit using the QA Tool “IMMUNIZATION REVIEW” (Attachement 5-C) for all new admissions for the next 12 months. The facility will do so to ensure ongoing compliance for a minimum of 12 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tools “PNUEMOCOCCAL IMMUNIZATION REVIEW” and "IMMUNIZATION REVIEW."	

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	August, to discuss the current flu vaccinations and pneumococcal vaccines for each resident. She verified the residents' vaccinations in the clinical record and on the Children and Hoosier Immunization Registry Program (CHIRP). The pharmacy and physician determined the appropriate vaccination for each resident. The IP utilized the consent form, which had an option to decline the vaccine. The consent forms were uploaded to the medical record as soon as possible. A current facility policy, dated 7/6/15, titled "Influenza and Pneumococcal Immunization Program," and provided by the Administrator on 10/30/24 following the entrance conference, indicated the following: "...It is the policy of Miller's Health Systems to administer annual Influenza and Pneumococcal vaccines, as recommended by APIC and the CDC, to all residents residing in the facility... The facility will administer immunizations in accordance with recommendations established by the Centers of Disease Control and Prevention in effect at the time the immunizations are administered..." A current facility policy, dated 10/11/22, titled "Pneumococcal Disease Immunization Procedure," and provided by the Infection Preventionist on 11/7/24 at 2:17 p.m., indicated the following: "...Pneumococcal vaccines PPSV 23 (Pneumococcal Polysaccharide vaccine) and PCV 15 and PCV 20 (Pneumococcal conjugate vaccines) will be offered, encouraged, and provided to all residents residing in the facility. The vaccine will be administered according to the Center for Disease Control and Prevention recommendations..." 3.1-13(a)			

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