STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. BUILDING 00 B. WING	08/29/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412002. Complaint IN00412002 - Federal/state deficiencies related to the allegations are cited at F684. Survey date: August 29, 2023 Facility number: 000194 Provider number: 155297 AIM number: 100267790 Census Bed Type: SNF/NF: 40 SNF: 11 Total: 51 Census Payor Type: Medicare: 17 Medicaid: 22 Other: 12 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/5/23.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Mitchell	Administrator	09/19/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services related to the lack of an assessment for a resident when the family had concerns with the resident potentially being shocked from his ICD (implantable cardioverter defibrillator) (sends a shock and resets an abnormal heartbeat back to normal) and not documenting resident's pulse daily as part of the plan of care for 3 of 3 residents reviewed for pacemaker/defibrillator devices. (Residents B, C, and D) Findings include: 1. Record review for Resident B was completed on 8/29/23 at 9:21 a.m. Diagnoses included, but were not limited to heart failure, hypertension, orthostatic hypotension, atrial fibrillation and cardiac pacemaker. The Medicare 5 Day Minimum Data Set (MDS) assessment, dated 4/28/23, indicated the resident was cognitively intact. A Care Plan, dated 2/28/23, indicated the resident had a pacemaker in place. Interventions included to count and record the apical pulse rate and rhythm for one full minute daily and notify the doctor if above 100 or below 60. The May 2023 Vitals tracking indicated the resident's pulse was not documented on the following days: 5/1, 5/2, 5/4-5/9, 5/13, 5/14, 5/16, 5/18, 5/23, 5/25, 5/26, 5/28-5/31/23 A Progress Note, dated 5/26/23 at 10:44 a.m.,	F 0684	**F684 Quality of Care** It is the policy of Miller's Health & Rehab La Porte to ensure that residents receive the necessary treatment and services related to lack of assessments and documenting resident's pulse daily as part of plan of care for pacemaker/defibrillator devices. · Resident B no longer resides at the facility. · Resident C has a follow up cardiology appointment scheduled 10/23/23. Until that time daily apical heart rate will be taken as ordered. · Resident D had a follow up cardiology appointment on 8/30/23. Orders were given to discontinue apical pulse daily. ·All residents residing in the facility have the potential to be affected by the alleged deficient practice ·An audit of all residents was completed on or before 9/15/23 ensuring that all residents with pacemakers/defibulators had orders in for heart rate monitoring if the Physician ordered it. ·An audit of all residents was completed on or before 9/15/23 ensuring that the option to record the heart was available to document in the EMR. · All licensed nurses and	09/15/2023

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	indicated the doctor was notified that the resident had chosen to stop all treatments and wished to be palliative care only. The resident's family was there and agreed with decision. A Nursing Assessment, dated 5/27/23, indicated the resident's blood pressure was 105/70, pulse 107, respirations 18 and oxygen saturation 96% (percent) on room air. A Progress Note dated 5/31/23 at 9:07 a.m., indicated the resident was declining. They received an order from the physician to have the pacemaker company come out to turn off the resident's ICD pacemaker. The record lacked any documentation an assessment, including the resident's vitals, had been completed since 5/27/23. A Progress Note, dated 5/31/23 at 2:00 p.m., indicated the resident was found without vitals. The family was at the bedside. An order was received from the physician to release the body to the funeral home. Interview with RN 1 on 8/29/23 at 11:03 a.m., indicated she was the resident's nurse the night before he had passed away. There were no concerns or observations the resident had any problems with his pacemaker. The next morning she came into work and the family stopped her and told her the resident was getting shocked from his pacemaker. She then went and reported this to the resident's nurse. Interview with LPN 1 on 8/29/23 at 11:08 a.m., indicated RN 1 had told her the family had concerns the resident's pacemaker was shocking him. She went and observed the resident and did		QMA's will be educated on or before 9/15/23on the "Pacemaker" policy and procedure (Attachment A). ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Administrator. ·The QA tool "Pacemaker QA Review" will be utilized 5x week x 4 weeks, 3x week x4 weeks, monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool "Pacemaker QA Review" (Attachment B) specifically monitoring care plan accuracy and revision.	

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	not believe the resident was getting shocked. The resident was incoherent at the time and was actively dying. She tried to explain to the resident's family the resident was dying and was probably having spasms from being in renal failure. The family requested to have the pacemaker turned off. She then went and spoke with the Unit Manager. They called the pacemaker company and they indicated they would come out to turn it off and the facility could place a magnet over the pacemaker to turn it off while waiting for a representative to arrive. LPN 1 indicated they did not have a magnet. They called a hospice company that came to the facility and borrowed one from them. She had placed the magnet and secured on the resident as best as she could with tape, but the resident was being restless and the magnet was not wanting to stay in place. She had not documented anything related to this incident or any assessment she had completed on the resident. Interview with the Unit Manger on 8/20/23 at 11:13 a.m., indicated LPN 1 had told her the resident's family was concerned he was getting shocked from his pacemaker and they wanted it turned off. She went and observed the resident and did not believe the resident was getting shocked. They notified the doctor and he said they could call the company and get it turned off. They called the company and were told they could use a magnet to turn it off until the company representative arrived. They tried to secure the magnet as best as they could with tape. The company came and turned off the resident's pacemaker prior to his passing that day. She had not documented anything related to the incident or any assessment she had completed on the resident. Interview with the Director of Nursing on 8/29/23			

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	at 3:10 p.m., indicated she had worked at the facility for 7 months and nursing had not been in-serviced during that time for pacemakers/defibrillators. She indicated a magnet was used to turn off a pacemaker/defibrillator. They did not keep magnets in the facility because the nurses are not ACLS (advanced cardiac life support) certified. If an incident happened, they would send the resident out to the hospital. Resident B's family did not want him sent out to the hospital, so that is why the nurse received the magnet and put it on the resident before the pacemaker company could come and turn it off. She indicated the pulse checked daily was supposed to be done until the first pacemaker check up. The resident had a checkup completed in April 2023 so the pulse did not need to be checked daily. The resident's care plan should have been updated to not include that intervention. Nursing should have documented the incident and any assessments they had completed on the resident. 2. Record review for Resident C was completed on 8/29/23 at 12:45 p.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, hypertension, and cardiomyopathy. The Admission MDS, dated 8/4/23, indicated the resident was cognitively intact. A Care Plan, dated 7/21/23 and revised 7/24/23, indicated the resident had a pacemaker. An intervention included to count and record the apical pulse for one full minute daily. The August 2023 Vitals indicated the resident's pulse was not documented on the following days: 8/2-8/4, 8/6, 8/7, 8/9-8/11, 8/13, 8/14, 8/16, 8/18, 8/20-8/24, and 8/27/23			

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	Interview with the Director of Nursing on 8/29/23 at 3:10 p.m., indicated the pulse checked daily was supposed to be done until the first pacemaker check up. The resident had a checkup completed already and the pulse did not need to be checked daily. The resident's care plan should have been updated to not include that intervention. 3. Record review for Resident D was completed on 8/29/23 at 1:07 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, heart failure, and cardiac pacemaker. The resident was admitted on 8/3/23. The Admission MDS assessment, dated 8/10/23, indicated the resident was cognitively intact. A Care Plan, dated 8/3/23 and revised 8/4/23, indicated the resident had a pacemaker in place. An intervention included to count and record the apical pulse for one full minute daily. The August 2023 Physician's Order Summary indicated the resident had a pacemaker placed on 7/27/23. An order was to check the apical pulse rate and rhythm daily for 1 minute. Notify the physician if above 110 or below 60. The August 2023 Treatment Administration Record (TAR) was checked off every day that the pulse was checked, but lacked a documented rate of the pulse. The August 2023 Vitals indicated the resident's pulse was not documented on the following days: 8/7, 8/8, 8/10, 8/12, 8/17-8/22, 8/24, 8/26, 8/27/23 Interview with the Director of Nursing on 8/29/23 at 3:10 p.m., indicated the resident's pacemaker			

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	was new and nursing should have documented the pulse rate each day. A facility policy titled, "Pacemaker Care Procedure" and received as current from the facility on 8/29/23, indicated, "...II. Check apical pulse rate & rhythm daily (MAR/TAR) for residents with new pacemaker..." This Federal tag related to Complaint IN00412002. 3.1-37(a)			