STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155589	A. BUILDING 00 B. WING	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	730 SCHOOL ST CULVER, IN 46511

(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: January 8, 9, 10, 11 and 12, 2024 Facility number: 000489 Provider number: 155589 AIM number: 100291210 Census Bed Type: SNF/NF: 47 SNF: 3 Total: 50 Census Payor Type: Medicare: 1 Medicaid: 35 Other: 14 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/19/24	F 0000	Please accept this POC as our allegation of compliance. We are respectfully requesting paper compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure medications were not stored at the bedside without authorization and evaluation to self administer for 2 random resident observations. (Residents 30 &	F 0554	Please accept the following POC as our allegation of compliance. We are respectfully requesting paper compliance. F- 554 Resident Self-Admin	02/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Hill	Administrator	02/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	203) Findings include: 1. During an interview on 1/8/2024 at 10:17 A.M., Resident 30 indicated she had a sore on her leg and they changed the dressing every day. She indicated staff keep the salve for the sore in her nightstand drawer. A bottle of Nyamyc Pow and bacitracin/zinc ointment from the facility pharmacy with the resident's name was noted in the drawer. In addition, there was an over the counter (OTC) bottle of liquid anesthetic, which was not labeled, in the drawer. During an observation on 1/10/2024 at 9:05 A.M., the Nyamyc Pow bottle was sitting on the resident's bedside tray table and the bacitracin and oral pain relief was in the nightstand drawer. A record review was completed for Resident 30 on 1/10/2024 at 10:18 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage 3, atrial fibrillation, edema, left lower leg blister, shortness of breath, and chronic diastolic congestive heart failure. During an interview on 1/10/2024 at 9: 22 A.M. the Licensed Practical Nurse (LPN) 11 indicated the nyamyc and bacitracin should have been in a bag in the treatment cart and there was no order for the Rexall oral pain relief and it should not have been in the facility. 2. A record review was completed on 1/10/2024 at 10:34 A.M. Diagnoses were included, but not limited to: cerebral infarction, obstructive sleep apnea, insomnia, and abnormal finding of lung field.		Meds-Clinically Appropriate It is the policy of Miller's Merry Manor that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1 To immediately correct this finding all identified medications were removed from the resident rooms and stored properly. 2 All residents have the potential to be affected by the same deficient practice. No other residents were affected. 3 To ensure that the deficient practice does not recur all Nurses and QMA's will be in-serviced on proper medication storage using the policy titled, Medication Storage, (Attachment A). 4 To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days a week for 2 weeks, then weekly	

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	During an interview and observation on 1/10/2024 at 10:50 A.M., Resident 203 indicated he had problems sleeping at night. He indicated the doctor had ordered something, but it was not working. His wife brought in some gummies about a month ago that were helping and he kept them in the bottom drawer of the nightstand. He indicated his wife gave him 3 gummies in a bowl along with some cookies and he ate them when he was ready for bed. A bottle of over the counter Melatonin 10 mg gummies was observed in the bedside drawer. The bottle contained 60 tablets and there was approximately one-fourth of the bottle left. During an interview on 1/10/2024 at 11:33 A.M., LPN 11 indicated Resident 203 currently did not have a written order for Melatonin and the medication should not have been in his room for self administration. A Progress Note, dated 1/4/2024 at 12:01, indicated "d/c ambien. pt [patient] may restart melatonin 10 mg (milligram) at HS (hour of sleep). Wife notified. She will bring in. She does not wish for any medication from our pharmacy or pyxis system. Will write order once wife bring in medications. Duane aware." A Care Plan, dated 10/12/2024 indicated "Insomnia: I have sleeplessness/insomnia." An intervention was to "administer medications as ordered - Ambien daily thru 12/31/ then start melatonin daily 1/1." On 1/11/2024 at 8:45 A.M. the Director of Nursing provided a policy titled,"Storage Of Medications," dated 4/24/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Medications and biologicals are		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 February 3, 2024	

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	stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...." 3.1-45(a)(1)			
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 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure treatments were carried out per Physician's Orders for 3 out of 3 residents reviewed for quality of care. (Residents 22, 30 & 32) Findings include: 1. During an observation on 1/9/2024 at 10:02 A.M. and 2:21 P.M., Resident 22 did not have a splint or a washcloth in her left hand. Her left hand was in a tight fist. During an observation on 1/10/2024 at 1:55 P.M., the resident did not have a washcloth in her left hand, it was in a tight fist. During an observation on 1/11/2024 at 9:23 A.M. and at 2:24 P.M., the resident did not have a	F 0684	F-684 Quality Of Care It is the policy of Miller's Merry Manor to ensure treatments are carried out per physicians' orders. 1 The facility immediately corrected the findings in accordance with the physicians orders. 2 All residents have the potential to be affected by the same deficient practice. No other residents were affected. 3 To ensure that the deficient practice does not recur all nurses	02/03/2024

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	washcloth in her left hand, it was in a tight fist. During an observation on 1/12/2024 at 12:15 P.M., the resident did not have a splint on or a washcloth to the left hand. A record review was completed for Resident 22 on 1/10/2024 at 1:20 P.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side, and contracture, left hand. A Physician's Order, dated 7/13/2023, indicated the resident was to wear a left hand splint from approximately 10 a.m. to 4 p.m. or as she tolerated, off for skin checks and hygiene, every day and evening shift. A Physician's Order, dated 12/26/2023, indicated to place a rolled wash cloth in the resident's left hand for contractures every shift. A Care Plan, dated 12/27/2023, indicated the resident had a contracture to her left hand with interventions of a left hand splint from 10 am-PM as tolerated and to place a rolled washcloth in the left hand as ordered. The Treatment Administration Record (TAR), dated 1/1/2024-1/31/2024, indicated the rolled wash cloth was applied on the following dates: 1/9/2024, 1/10/2024, 1/11/2024 and 1/12/2024 on all three shifts. A left hand splint was applied on 1/9/2024 and 1/12/2024. During an interview on 1/10/2024 at 2:00 P.M., LPN 11 indicated the resident should have had the wash cloth and hand splint applied. The nurse could not locate the splint in the room.		will be in-serviced on the policy titled, New Order Transcription (Attachment C). The review of this policy will ensure all nurses are familiar with the EMR, order categories and carrying out orders as ordered by the Physician. 4 To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days 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 February 3, 2024	

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	2. During an observation and interview on 1/8/2024 at 10:23 A.M., Resident 30 had kerlix gauze wrapped around her left lower leg dated 1/7/2024 with initials of AB. The resident was not wearing any TED (Thrombo-Embolic Deterrent) hose on her right leg. During an observation on 1/9/2024 at 9:49 A.M., Resident 30's dressing to the left lower leg was dated 1/7/2024 with initials AB and had yellow drainage seeping thru the kerlix. The resident was not wearing any TED hose on her right leg. During an observation on 1/10/2024 at 1:38 P.M., the resident was not wearing any TED Hose to the right leg. A record review was completed for Resident 30 on 1/10/2024 at 10:18 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage 3, atrial fibrillation, edema, left lower leg blister, shortness of breath, and chronic diastolic congestive heart failure. A Physician's Order, dated 12/26/2023, indicated to cleanse the left lower extremity with normal saline and apply triple antibiotic ointment and dry dressing daily. A Physician's Order, dated 8/9/2023, indicated TED Hose to the right lower extremity on in A.M. and off in P.M. A Care Plan, dated 12/26/2023, indicated a plan to address a "blister- at risk for complications to the left lower extremity," with interventions to administer a treatment of antibiotic ointment and cover with a dry dressing daily.			

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	A Care Plan, dated 7/26/2023, indicated she had edema (swelling) to lower extremities with an intervention of TED Hose as ordered. The TAR (Treatment Administration Record), dated 1/1/2024-1/31/2024, indicated the right lower leg TED Hose was applied on 1/8/2024, 1/9/2024 and 1/10/2024. During an interview on 1/10/2024 at 9:11 A.M., LPN 11 indicated Resident 30's dressing to her left leg was to be changed daily. She confirmed the dressing, when removed yesterday, had a lot of yellow drainage on it. During an interview on 1/10/2024 at 1:47 P.M., LPN 11 indicated the resident should have had on the TED Hose to the right lower leg. 3. During an observation on 1/9/2024 at 10:06 A.M., Resident 32 was sitting in her recliner in an upright position with no helmet in place. A soft helmet was noted on her bedside table. During an observation on 1/11/2024 at 10:51 A.M. the resident was sitting in her recliner leaning forward at the waist with her head perpendicular to her knees, and the leg rest to the recliner slightly raised. Her helmet was sitting on the bedside table. A record review was completed on 1/11/2024 at 10:55 A.M. for Resident 32. Diagnoses included, but were not limited to: nontraumatic intracerebral hemorrhage in brain stem, type 2 diabetes, aphasia, and seizures. A Physician's Order, dated 5/15/2023, indicated Resident 32 was to wear her helmet when out of bed every shift.			

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A Care Plan, dated 5/23/2023, indicating she was a fall risk due to her condition, risk factors, diagnoses and history or weakness and seizures. An intervention indicated for her to wear a helmet when out of bed.

The TAR (Treatment Administration Record), dated 1/1/2024-1/31/2024 indicated she was wearing it on 1/9/2024 and 1/11/2024 on day shift when out of bed.

During an interview on 1/11/2024 at 10:59 A.M., CNA 5 indicated Resident 32 was not a fall risk. Resident 32 wore the helmet during transfers and when she was in her wheelchair.

During an interview on 1/11/2024 at 11:12 A.M., RN 3 indicated she did not think the resident was a fall risk and her husband did not want her to wear the helmet when she was in the recliner. There was no documentation or plan located to support the statement regarding Resident 32's husband's preference for her not to wear the soft helmet when she was seated in the recliner.

During an interview on 1/11/2024 at 11:24 A.M. the Director of Nursing (DON) indicated if staff put Resident 32's helmet on, she would remove it when she was in the recliner. It should have been care planned under preferences when someone refused, but no plan could be located.

On 1/11/2024 at 8:45 A.M. the DON indicated the facility did not have a policy for splints or following Physician Orders.

3.1-37(a)

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure respiratory equipment/tubing was properly stored when not in use and distilled water was labeled for 1 out of 3 residents reviewed for respiratory care. (Resident 26) Finding includes: During an observation on 1/8/2024 at 11:28 A.M., Resident 26's continuous positive airway pressure (CPAP) nasal cushion and tubing was hanging from the bed headboard with half of the tubing on the floor. One of two partial gallons of distilled water had no open date, and the other gallon of water was marked with the residents name and it indicated it was for CPAP machine, but was undated. The record review was completed for Resident 26 on 1/11/2024 at 9:15 A.M. Diagnoses included, but were not limited to: Parkinson's Disease, type 2 diabetes, obstructive sleep apnea and edema. During an interview on 1/11/2024 at 11:52 A.M., RN 3 indicated when the CPAP was not in use, the tubing should be in a bag and the bottled water	F 0695	F- 695 Respiratory/Tracheostomy Care and Suctioning It is the policy of Miller's Merry Manor to ensure respiratory equipment is labeled and stored properly. 1 Facility immediately corrected findings by replacing distilled water and providing a place for mask to be stored when not in use. 2 No other residents were affected by this same deficient practice. 3 To ensure that the deficient practice does not recur all Nurses will be in-serviced on the policy titled, CPAP/BiPAP (Attachment D). Special emphasis will be given to information on distilled water and storing mask when not in use.	02/03/2024

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	should have an opened date. On 1/11/2024 at 3:29 P.M., the Director of Nursing indicated she did not have a policy on the storage of respiratory equipment when not in use or a policy regarding the distilled water. 3.1-47(6) . .		4 To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days 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 February 3, 2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and			

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	Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interviews, the facility failed to over the counter medications were labeled properly for 2 of 2 medication carts observed. In addition, the facility failed to ensure insulin was not expired for 1 of 2 medication carts. Findings include: 1. During an observation of the medication cart for the Grand unit with LPN 10 on 1/11/2024 at 1:11 P.M., the following was noted: A bottle of Calcium tablets had Resident 9's name written on the bottle but the physician's name and dose were not written on the bottle, A bag of Halls Defense cough drops had no resident name, physician's name or dose instructions on the bag. During an interview with LPN 10, she indicated the cough drops belonged to Resident 9. A box of Alka Seltzer severe cold and cough	F 0761	F- 761 Label/Store Drugs and Biologicals It is the policy of Miller's Merry Manor to medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. 1 The facility took immediate action to correct the finding by removing all expired medications from the active supply and destroying. The facility labeled all OTC medications appropriately. 2 All residents have the potential to be affected by the same deficient practice. No other medications were noted to be affected once audited completely.	02/03/2024

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	medication had no resident or physician's name and no dose instructions, except the manufacturer's instructions. During an interview with LPN 10, she indicated the cold medication was brought in by Resident 9's family. An unopened bottle of low dose aspirin tablet and a second bottle with just one tablet of low dose aspirin tablets left had no resident name, physician's name, or dose instructions on the bottle. During an interview with LPN 10 she indicated the medication belonged to Resident 9. An opened bottle of Calcium with Vitamin D tablets had the name of Resident 40, but no physician's name or dose instructions on the bottle. An opened bottle of Macular health vitamins had no resident name, physician's name or dose instructions. During an interview with LPN 10, she indicated the vitamins belonged to Resident 40. An opened box of allergy relief medication had no resident or physician's name and no dose instructions. During an interview with LPN 10, she indicated the medication belonged to Resident 40. An opened box of Salon pas pain relief patches had the name and room number of Resident 40 but no ordering physician's name or dose instructions. A bottle of acetaminophen extra strength tablets had no resident or physician's name and no dose instructions. During an interview with LPN 10, she indicated the medication belonged to Resident 40. She indicated Resident 40 was		3 To ensure that the deficient practice does not recur all Nurses and QMA's will be in-serviced on the policy titled, Storage of Medications (Attachment A) and the Medication Expiration Guideline Chart (Attachment E). 4 To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days 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 February 3, 2024	

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	switching to the facility pharmacy and she would probably return the Acetaminophen tablets to her daughter. 2. The following was noted during an observation of the Victory medication cart with RN 3 on 1/11/2024 at 1:30 P.M.: An opened bottle of Melatonin gummies had no resident's name, physician's name or dose instructions. During an interview with RN 3, on 1/11/2024 at 1:30 P.M., she indicated the Melatonin gummies belonged to Resident 203. An opened box of Mucinex only had Resident 203's name on it, but there was no ordering physician's name or dose instructions on the box. An opened bottle of Novulin R insulin for Resident 10 had an open date of 12/1/2023 on the bottle. An opened bottle of Novolog insulin for Resident 33 had an opened date of 11/29/2023 on the bottle. An opened bottle of Lantus insulin for Resident 14 had an opened date of 11/29/2023. During an interview with RN 3, on 1/11/2023 at 1:35 P.M., she indicated once the insulin was opened and not refrigerated, it expired in 30 days. She confirmed the insulin bottles for Residents 10, 14 and 33 were all expired and should have been discarded. Review of the facility policy and procedure, titled, "Medication Labels," provided by the MDS nurse on 1/12/2024 at 10:00 A.M., included the following: "...5. Resident - specific nonprescription medications (not floor			

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	stock/OTC) that are not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information listed above (see B) is not covered...." The section of the policy, labeled "B" included the following: "...B. Specific directions for use, including route of administration...." Review of the facility policy and procedure, titled, "Storage of Medications," provided by the MDS nurse on 1/12/2024 at 10:00 A.M. included the following: "...5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place as "date opened" sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a "date opened" and "expiration" notation line). The expiration date of the vial or container will be (30) days unless the manufacturer recommends another date or regulations/guidelines required differed dating...8. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner..." 3.1-25 (l)(1) 3.1-25(l)(2) 3.1-25(o)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed store food and equipment properly related to undated opened food, and air-dry pitchers, coffee cups and resident's water cups not in an inverted position free from dust and contaminates for 1 of 1 kitchens observed. (Main Kitchen) This had the potential to affect 50 out of 50 residents who received food from the kitchen. Findings include: 1. During a tour of the kitchen with the Dietary Manager (DM) on 1/8/2024 between 9:20 A.M. - 9:44 A.M., there were 3 dessert dishes with yogurt, 2 with mandarin oranges, one tomato slice, 2 individual cups of salad dressing and an open bag of grapes in the refrigerator undated. There were 5 of 8 opened packages of hamburger buns undated on the open bread rack. During an interview on 1/8/2024 at 9:29 A.M., the	F 0812	F-812 Food Procurement, Store/Prepare/Serve-Sanitary It is the policy of Miller's Merry Manor to store food and equipment properly. 1 Immediate action taken was the review of appropriate policies with each staff member involved in the finding. 2 All residents have the potential to be affected by this practice. 3 To ensure that the deficient practice does not recur all cooks and dietary aides will be in-serviced on the following policies; Food Preparation, Food Handling and Service policy	02/03/2024

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	DM indicated the items should have been dated when they were opened. 2. During a follow up visit to the kitchen for operation of the dishwasher, there was a fan attached to the wall facing the dish machine on high speed. Under the fan, there was a cart with water cups and lids positioned on their side. There were also juice/water pitchers noted on a wall rack above the table attached to the dishwasher, also lying on their sides. Finally, there were coffee cups at the end of the table on a cart, stacked on a tray positioned on their side all facing the aisle. During an interview on 1/12/2024 at 10:40 A.M., the Dietary Aide indicated this was how they had always air dried the cups and pitchers. After they dried, she would take the coffee cups to the dining room and invert them on a tray, put the pitchers in the cabinet and take the residents' water cups to the units. She acknowledged that they could become contaminated from any particles the fan blew into the inside of the cups/dishes. On 1/12/2024 at 12:00 P.M., the Dietary Manager provided a policy titled, "Equipment and Utensils - Cleaning and Sanitizing," dated 9/15/2015, and indicated the policy is the one currently used by the facility. The policy indicated..." 3. After sanitation, all equipment and utensils are air-dried, then handled and stored covered or inverted." 3.1-21(i)(3)		(Attachment F), Food Protection and Storage policy (Attachment G), and Equipment and Utensils-Cleaning and Sanitizing (Attachment H). 4 To monitor the corrective actions and ensure the deficient practice will not recur, the Dietary Manager/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days 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 February 3, 2024	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	1. Based on observation, record review and interview, the facility failed to ensure 2 of 4 nursing staff (QMA 7 and LPN 8) administering medications followed infection control policies regarding hand washing and equipment cleaning and storage and 1 of 2 nursing staff (LPN 4) followed infection control policies during a dressing change. Findings include: 1. During an observation of a medication pass,	F 0880	F-880 Infection Prevention & Control It is the policy of Miller's Merry Manor to provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection.	02/03/2024

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	conducted on 1/8/2024 at 11:54 A.M., LPN 8 obtained the blood glucose level of Resident 33 utilizing a Lancet and glucometer. After obtaining the blood glucose level, before she left the resident's room, LPN 8 placed the used glucometer in a small plastic container on top of unused alcohol swabs and unused lancets and carried the items to her medication cart. Once she arrived at her medication cart, after charting the blood glucose levels in her computer, LPN 8 then cleaned and sanitized the glucometer. During an interview with LPN 8 on 1/8/2024 at 12:02 P.M., she confirmed each medication cart had two glucometers which were to be cleaned and sanitized in between residents. She indicated the procedure was to wipe the glucometer off with a Lysol disinfectant wipe and then wrap the glucometer in a Microdol bleach wipe so the surface of the glucometer remained "wet" for one minute. The facility policy and procedure, titled, "Injection - Subcutaneous Procedure", provided by the Administrator on 1/12/2024 at 10:15 A.M., did not address obtaining the blood glucose level or cleaning of the glucometers. 2. During an observation of a medication pass, conducted on 1/9/2024 from 3:17 P.M. to 3:30 P.M., QMA 7 administered oral medications to Residents 7, 27, 36 and 47. QMA 7 did not wash her hands and/or utilize alcohol sanitizing gel to clean her hands in between residents. The facility policy and procedure, titled "Hand Washing and Hand Asepsis" provided by the Administrator on 1/12/2024 at 10:15 A.M. included the following: "...3. Key Procedural Points: A. SPECIFIC TIMES HANDS MUST BE WASHED:		1 The immediate action taken was the review of appropriate policy with each staff member involved in the finding. 2. There were no other residents affected by this deficient practice. 1 To ensure that the deficient practice does not recur all Nurses and QMA's will be in-serviced on the following policies; Hand washing and hand asepsis (Attachment I), Medication Administration Policy (Attachment J), Cleaning of Glucometer (Attachment K) and Dressing-Clean Procedure (Attachment L). 4 To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 1-12-24 POC, (Attachment B). This tool will be completed 5 days 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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	...III. Before and after direct resident contact...." The facility policy and procedure, titled "Medication Administration" provided by the Administrator on 1/12/2023 at 10:15 A.M. included the following: "20. Administer medications... 21. Remain with the resident until each medication is swallowed. Never leave medication with the resident. 22. Perform hand hygiene...." 3. During an observation of a dressing change to Resident 30's left lower leg on 1/10/2024 at 9:35 A.M., LPN 4 removed the soiled kerlix from the resident, picked up the dressing which was sticking to wound, removed her gloves and donned new gloves, then opened 2 packages of gauze. During an interview on, 1/10/2024 at 9:37 A.M., LPN 4 indicated she should have washed her hands when removing her soiled gloves. During an observation on 1/10/2024 at 9:41 A.M., LPN 4 removed her gloves, collected her supplies and put them in the basket, took her scissors and washed them at the sink, set them down and applied soap to her hands, scrubbed for 3 seconds, rinsed, then dried. During an interview on 1/10/2024 at 9:42 A.M., LPN 4 indicated she sang Happy Birthday twice while she was washing her scissors with her hands and should have washed her hands after the scissors for 30 seconds. A record review was completed for Resident 30 on 1/10/2024 at 10:18 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage 3, atrial fibrillation, edema, left lower leg blister, shortness of breath, and chronic diastolic congestive heart failure.		reviewed at the monthly QAPI meeting with changes made as appropriate. 5 All systemic changes will be completed by February 3, 2024.	

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	On 1/11/2024 at 8:45 A.M. the Director of Nursing provided a policy titled,"Dressing-Clean Procedure," dated 7/14/2014, and indicated it was the one currently used at the facility. The policy indicated "...7. Remove soiled dressings and discard in plastic bag, including gloves. 8. Wash hands. 9. Apply clean gloves and cleanse wound with prescribed solution. Discard gloves in plastic bag. Wash hands. 10. Apply clean gloves, apply medication, if prescribed, apply dressing and secure with tape. Use tape on skin only when there is no way to tape dressing-to-dressing. 11. Remove treatment changed under wound area and discard with soiled dressing, disposable equipment, and gloves in plastic bag. Tie off bag. 12. Wash hands...." 3.1-18(l)			