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	12/02/2022

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: November 28, 29, & 30. December 1 & 2, 2022 Facility number: 000489 Provider number: 155589 AIM number: 100291210 Census Bed Type: SNF/NF: 38 Total: 38 Census Payor Type: Medicare: 4 Medicaid: 23 Other: 11 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/5/22.	F 0000	Please accept the following remedies for the deficiencies cited. We respectfully request paper compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure an Admission MDS Assessment was accurate for 1 of 17 residents whose assessments were reviewed. (Resident 40) Finding includes:	F 0641	Please see the remedies below to correct deficiencies cited. We respectfully request paper compliance. **F- 641 Accuracy of Assessments** It is the policy of Miller's Merry	12/24/2022

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

Jason Hill | Administrator | 12/22/2022

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	A clinical record review was completed, on 11/30/2022 at 6:03 A.M. Resident 40's current diagnoses included cancer of cerebellum, seizers, dysphagia, hypertension and BPH (benign prostatic hyperplasia). An Admission MDS (Minimum Data Set) Assessment, dated 10/13/2022, lacked documentation of any diagnoses. During an interview, on 12/01/2022 at 8:56 A.M., RN 4 indicated the assessment was inaccurate and should have had the diagnoses checked on it. During an interview, on 12/1/2022 at 11:19 A.M., the Director of Nursing indicated the facility used the RAI (Resident Assessment Instrument) as their policy. On 12/2/2022 at 2:43 P.M., the Director of Nursing provided the policy titled," Comprehensive Assessments (MDS), dated 1/23/2020, and indicated the policy was the one currently used by the facility. The policy indicated"... B. The assessment is to describe the resident's capabilities to perform daily life functions and to identify significant impairments in functional capacity. 2. Procedure: ...B. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and includes, as a minimum, the following: I. Medically defined conditions and prior medical history. II. Medical status measurement. III. Physical and mental functional status...."		Manor that within fourteen days of the resident's admission, a comprehensive assessment of the resident's needs will be completed by the interdisciplinary team using the resident assessment instrument (RAI) specified by OBRA.. 1. Resident #40’s admission MDS was modified with the correct information. 2. All residents have the potential to be affected by the same deficient practice. An audit was completed and no other residents were affected. 3. To ensure that the deficient practice does not recur the MDS Coordinator was in-serviced on the policy titled, Comprehensive Assessments (MDS), (Attachment A), with emphasis placed on the completion of section I (Active Diagnosis) and use of the RAI manual when needed. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual 12-2-22 POC, (Attachment B). This tool will be completed on all newly completed Admission MDS’s daily (M-F) for 2 weeks, then weekly for 4 weeks, then monthly for 3	

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			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 12/24/22	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents received assistance related to daily living needs regarding bathing needs. (Resident 35) Finding includes: During a random observation of Resident 35's electronic shower documentation, on 11/29/2022 at 10:30 A.M., the following documentation was noted: a shower was documented as received on 11/1, 11/2, 11/4, 11/12 and 11/29/2022, with no documentation of any refusals of showers. During an interview, on 11/29/2022 at 10:30 A.M., QMA (qualified medication aide) 2 indicated the	F 0677	**F- 677 ADL Care Provided for Dependent Residents** It is the policy of Miller's Merry Manor to document information in the electronic medical record. The Point of Care program (POC) is where the daily care (ADL's), activities and restorative tasks are documented. 1. Resident # 35 bathing preferences were reviewed, updated as needed and bathing scheduled to meet preferences. 2. All residents have the	12/24/2022

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	resident did not have 2 showers per week per the documentation. A paper shower sheet for Resident 35 was provided for November 2022, and indicated the resident had received a shower on 11/1, 11/2, 11/4, 11/8, 11/12 and 11/29/2022. The shower schedule for the resident indicted she was to receive showers on Tuesdays and Fridays. Review of the paper and electronic shower documentation lacked the documentation to show that a shower had not been received for 16 days from 11/13/2022 to 11/29/2022. A current care plan, dated 6/28/2022 indicated: Late loss ADL's. The resident needs limited to extensive assist with eating/drinking. Extensive assist with bed mobility, extensive assist with toileting, and have had a stroke and have aphasia and unable to care for myself at this time. A current care plan, dated 7/27/2021, indicated Resident 35's preferences were: expressed during the assessment process, that it is important to her to choose for bathing-showers as scheduled and allowed with restrictions. Liked showers in the morning but ok to take in the afternoon. During an interview, on 12/01/2022 at 8:50 A.M., CNA 5 indicated she is usually the bath aide and will document the showers on the shower sheet and in point click care (electronic chart). On 12/2/2022 at 2:43 P.M., the Director of Nursing provided the policy titled," Point of Care Documentation & Legends", dated 9/23/2014, and indicated the policy was the one currently used by the facility. The policy indicated"...A. It is the		potential to be affected by the same deficient practice. All residents bathing preferences were reviewed, updated if needed and bathing scheduled to meet preferences. 3. To ensure that the deficient practice does not recur all nursing staff will be in-serviced on the policy titled, Point of Care Documentation & Legends (Attachment C) by 12/22/22. This in-serving will include specific education on bathing documentation option and the importance of documenting all refusal. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual 12-2-22 POC, (Attachment B). This tool will be completed for scheduled showers/baths daily (M-F) 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	

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	policy of [Name of Facility] to document information in the electronic medical record. The Point of Care Program (POC) is where the daily care (ADL's), activities and restorative tasks are documented. 2 . Procedure A. Staff will document care immediately following the completion of a task or by the end of their shift. ...B. Routine tasks assigned to all residents are: Document Bath/Shower each shift...." 3.1-38(a)(3)		meeting with changes made as appropriate. 5. All systemic changes will be completed by 12/24/22.	
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 record review and interview, the facility failed to follow physician orders for pain medication in 1 of 2 residents reviewed for pain. (Resident 44) Finding includes: A clinical record review was completed on 12/1/2022 at 11:00 A.M. Resident 44's diagnoses included, but were not limited to: fractured shaft of right humerus, fracture of the left humerus, Guillain-Barre Syndrome and bipolar. A Physicians' Order, dated November 23, 2022, indicated Resident 44 was to receive Hydrocodone-Acetaminophen 10/325 mg	F 0684	**F- 684 Quality of Care** It is the policy of Miller's Merry Manor to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration. 1. Resident #44's MD was notified of order, timed out and new order received. 2. All residents have the potential to be affected by the	12/24/2022

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	(milligrams) 1 tablet every 4 hours as needed for moderate to severe pain for 7 days with a start date of 11/23/2022. A current care plan, dated 11/8/2022, indicated the resident had the potential for pain/discomfort related to my diagnosis. The November MAR (Medication Administration Record) indicated the narcotic medication was started on 11/23/2022 and was given through 11/30/2022, 8 total days. During an interview, on 12/2/2022 at 11:26 A.M., the Director of Nursing indicated the added dose should not have been given and would be considered a medication error. On 12/2/2022 at 2:43 P.M., the Director of Nursing provided the policy titled," Physician Order Transcription Procedure", dated 6/15/2010, and indicated the policy was the one currently used by the facility. The policy indicated"...G. 1. New orders- Medications ordered for a specific time frame i.e. x 7 days, shall be added to the MAR and will be numbered off or x' d off to ensure only the amount ordered are given...." 3.1-37		same deficient practice. All time specific orders were audited for correct transcription. No other resident were affected. 3. To ensure that the deficient practice does not recur all Nurses will be in-serviced on the policy titled, Physician Order Transcription Procedure (Attachment D) by 12/22/22. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual 12-2-22 POC, (Attachment B). This tool will be completed on all new orders that are timed daily (M-F) 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 12/24/22.	