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	05/22/2024

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

(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: May 16, 17, 20, 21, and 22, 2024 Facility number: 000194 Provider number: 155297 AIM number: 100267790 Census Bed Type: SNF/NF: 43 SNF: 11 Total: 54 Census Payor Type: Medicare: 17 Medicaid: 22 Other: 15 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/30/24.	F 0000		
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including			

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

Kari Mitchell | Administrator | 06/14/2024

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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	sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure a resident's preferences were honored related to the type of diet they received for 1 of 1 resident reviewed for choices. (Resident 50) Finding includes: During an interview on 5/16/24 at 10:23 a.m., Resident 50 indicated there was one issue that kept upsetting her. She indicated her doctor told her she could have whatever she wanted to eat, however, the staff here kept telling her she cannot have certain items. On Mother's Day, she was in the dining room and everyone at her table received ham and she got something else to eat. She asked the staff if she could have a piece of ham and was told "No". She then handed the person the plate and said "I want ham so get it for me please." The staff took the plate and brought	F 0561	**F561 Self-Determination** It is the policy of Miller's Health & Rehab La Porte to ensure that resident's preferences are honored related to the type of diet they receive. Resident #50 was educated on diet ordered by physician. All residents residing in the facility have the potential to be affected by the deficient practice. All staff were educated on resident's right to choose on or before June 14, 2024. When request are made outside of prescribed diet recommendations resident will be educated. If resident still requests item it will be given. All staff will be re-educated on or	06/14/2024

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	back a piece of ham and mashed potatoes but there was no gravy on the potatoes. She asked the staff where the gravy was for the potatoes, and the staff stated, "Well you wanted the ham so you do not get gravy on the potatoes because that is too much salt." During an interview on 5/20/24 at 9:10 a.m., the resident indicated she was able to get what she wanted for her meals over the past weekend with no issues, however, every day she has had to ask for bacon even though she wrote it on her meal ticket. Sometimes she received it and sometimes she did not. The meal ticked indicated the resident was to receive a 3-4 gram sodium diet. The record for Resident 50 was reviewed on 5/17/24 at 1:37 p.m. The resident was admitted to the facility on 4/23/24. Diagnoses included, but were not limited to, histoplasmosis (infection by a fungus found in the droppings of birds and bats in humid areas), chronic kidney disease, type 2 diabetes, respiratory failure, hepatic fibrosis, thrombocytopenic purpura, and high blood pressure. The 4/30/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, initiated on 4/23/24, indicated the resident needed limited to extensive assist with ADL's (Activities of Daily Living) since the recent hospital stay and required set up to supervision with eating. The approaches were staff will assess and honor her preferences. Physician's Orders, dated 4/24/24, indicated 3-4 gram sodium controlled carbohydrate diet.		before June 14, 2024 on the "Resident's Rights" (Attachment A). Dining Room Managers and dietary staff will review dietary request per menu to ensure requests are being granted. The Dietary Manager or other designee will be responsible to complete the QA tool "Self Determination QA Review". This tool will be completed 5x week x 4 weeks, weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Self Determination QA Review" (ATTACHMENT B) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing indicated the resident was cognitively intact and had not further information to provide. 3.1-3(u)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure individualized Care Plans were developed and implemented related to behaviors for 1 of 15 residents reviewed for care plan development and implementation. (Resident 22) Finding includes: During an observation and interview on 5/16/24 at 10:25 a.m., Resident 22 voiced concerns of another resident stealing items from her room and indicated the same resident smacked her in the face after she had snatched a marker out of the other resident's hand. The resident indicated this resident consistently steals from everyone and she was attempting to stop her from stealing the marker. She indicated the Director of Nursing was informed about the incident. The resident's allegations of abuse were reported to the Administrator on 5/16/24 at 11:55 a.m. The Administrator indicated she was unaware of this incident and would report and investigate the	F 0656	**F656 Develop/Implement Comprehensive Care Plan** It is the policy of Miller's Health & Rehab La Porte to individualized Care Plans are developed and implemented related to behaviors. Resident #22 care plan was updated to include behaviors. All residents residing in the facility have the potential to be affected by the deficient practice. All residents care plans were audited to ensure behaviors had been documented. Those needing updating were completed on or before June 14, 2024. All licensed nursing staff were educated on or before June 14, 2024 on the "Behavior Assessment and management" policy and procedure (Attachment C). The DON or designee will be responsible to complete the QA	06/14/2024

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	matter. Resident 22's record was reviewed on 5/16/24 at 11: 00 a.m. Diagnoses included, but were not limited to, major depressive and anxiety disorder. An Annual Minimum Data Set assessment, dated 4/10/24, indicated the resident was cognitively intact for daily decision making and had no behaviors. During an interview on 5/21/24 at 2:17 p.m., the Director of Nursing indicated there was a Care Plan regarding the resident's exaggerations and/or telling lies. A Care Plan, dated 5/20/24 after the resident's allegation, indicated the resident had a history of making false allegations that have been investigated and proven to be false. The resident reported that she had told staff concerns and then went back and told others she didn't report things. The Care Plan also indicated the resident's daughter reported that historically, the resident lied and not to believe anything that she said. During an interview on 5/22/24 at 8:30 a.m., the Administrator indicated a Care Plan meeting was held on 4/10/24 with the resident, her daughter, the Director of Nursing, and herself. At that time, the resident informed them that she had taken the marker out of another resident's hand, however, she never once said the resident had hit her. The Administrator indicated the resident would be very nice to the alleged resident and invite her in her room and give her cookies and candy, and then the next time the other resident went into her room, she was yelling at her to leave the room and accused her of taking items. She indicated there was no Care Plan in the resident's clinical record		tool “Comprehensive Care Plan” 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. Findings 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 “Comprehensive Care Plan” (ATTACHMENT D) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	regarding her manipulative behavior with the alleged resident, or any interventions, prior to 5/20/24. 3.1-35(a)			
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, record review, and interview, the facility failed to ensure bruised areas were assessed and monitored, and non-pressure skin treatments were completed as ordered, for 2 of 4 residents reviewed for non-pressure skin conditions. (Residents 40 and 6) Findings include: 1. During a random observation on 5/17/24 at 9:00 a.m., Resident 40 was observed in a recliner chair in her room. At that time, a bruise was noted under the left eye. On 5/20/24 at 12:10 p.m., the resident was observed sitting in a wheelchair eating lunch in the main dining room. At that time, the bruise remained under the left eye. The record for Resident 40 was reviewed on 5/17/24 at 11:14 a.m. The resident was admitted to	F 0684	**F684 Quality of Care** It is the policy of Miller's Health & Rehab La Porte to ensure areas of bruising were assessed and monitored and non-pressure skin treatments were completed as ordered. Resident #40 no longer resides at the facility. Resident #6 no longer resides at the facility. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers completed a head to toe skin assessment on readmitted residents on 6/12/2024. All abnormal findings had MD and RP notification with follow up on 6/12/2024. All nursing staff were re-educated on or before June 14, 2024 on the	06/14/2024

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	the facility on 4/17/24. Diagnoses included,but were not limited to, fractured ribs, Alzheimer's disease, high blood pressure, acute kidney failure, falls, type 2 diabetes, high blood pressure and anxiety. The 4/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Care Plan, initiated on 4/17/24, indicated the resident was at risk for skin breakdown. The approaches were to monitor skin daily with care and perform a weekly skin assessment by the nurse. Physician's Orders, dated 4/18/24, indicated to monitor bruise to left eye, face, neck, and back of head for 7 days and report any changes. The resident was admitted to the hospital on 5/3/24 and returned on 5/6/24. The Nursing Acute Return Assessment, dated 5/6/24, indicated the resident's skin was intact with no pre-existing bruising under the left eye. The Nursing-Assess Skilled (every shift times 72 hours then daily) Assessment, dated 5/7/24 at 12:30 a.m., indicated no skin issues old or new. There was no documentation in Nursing Progress Notes on 5/6-5/16/24 regarding the bruise under the left eye. During an interview on 5/17/24 at 1:45 p.m., CNA 1 indicated the resident had not had a fall since she had been here, and the bruise was old from when she was first admitted.		"Skin Management program" policy and procedure (Attachment E). The DON or designee will be responsible to complete QA tool "Quality of Care QA Review" 5x week x 4 weeks, weekly x4 weeks than 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 "Quality of Care QA Review" (ATTACHMENT F) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	During an interview on 5/17/24 at 2 p.m., RN 1 indicated the bruise was from her fall prior to coming into the facility and it was monitored on the Treatment Administration Record. During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing indicated after the resident returned from the hospital on 5/6/24, the bruise should have been assessed as pre-existing and monitored again. The current 4/23/24 "Wound (Pressure Injury) and Non-Wound Assessment and Documentation" policy, provided by the Administrator on 5/21/24 at 1:37 p.m., indicated non-wound skin altercations such as bruising will be monitored at least daily for 7 days for complications such as pain that may indicate further assessment. 2. On 5/16/24 at 10:02 a.m., Resident 6 was observed lying in bed with her heels floated. There was a dressing on the residents right foot dated 5/14/24. The resident indicated the treatment for her foot was to be completed daily. On 5/16/24 at 11:11 a.m., the resident was observed sitting up in bed. The dressing on her right foot had not been changed yet and was still dated 5/14/24. On 5/16/24 at 12:00 p.m., the resident was observed lying in bed with family at the bedside. The dressing had not been changed yet and was dated 5/14/24. During an interview at the time, the resident indicated the nurse communicated she would come back and change her right foot dressing on 5/15/24. The nurse had not come back to change it.			

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	The record for Resident 6 was reviewed on 5/20/24 at 3:42 p.m. The diagnoses included, but were not limited to, heart failure, depression, kidney disease, and cellulitis of the right leg. The Significant Change Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making and she had impairment of both legs. A Physicians' Order, dated 5/9/24, indicated to cleanse the right heel with saline, pat dry, apply betadine, cover with a non adherent dressing, and wrap with kerlix daily and as needed. A Nurses' Note, dated 5/9/2024 at 9:42 a.m., indicated the resident had a new non-pressure wound to the right posterior heel. Interventions were to cleanse with saline, apply betadine, cover with a non adherent dressing, and wrap with kerlix. The dressing was to be changed daily and as needed for soilage. During an interview on 5/16/24 at 12:06 p.m., Agency LPN 1 indicated the hospice nurse changed the dressings on days she provided care. When the hospice nurse was not in the facility, the nurse would be responsible for daily dressing changes. During an interview on 5/21/24 at 9:13 a.m., the Director of Nursing (DON) indicated she understood the concern regarding the missed dressing change and had no additional information to provide. 3.1-37(a)			
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed ensure adequate supervision was provided for a resident related to fall interventions for 1 of 1 resident reviewed for falls. (Resident 48) Finding includes: During a random observation on 5/16/24 at 11:30 a.m., Resident 48 was observed in bed. At that time, the bed was observed in a high position and there was no floor mat next to either side of the bed. The resident's spouse was seated in a chair by the window. On 5/17/24 at 9:00 a.m., the resident was observed in bed and CNA 1 was getting him dressed. At that time, the bed was in a very high position and the floor mat was against the wall. The CNA indicated she was preparing to get him up in the wheelchair by using the hoyer lift. At 9:05 a.m., the CNA left the room to get the hoyer lift and left the bed in the high position with the floor mat against the wall while the resident was still in the bed. At 9:11 a.m., the CNA came back to the unit with the hoyer lift and proceeded to get the resident into the chair. On 5/20/24 at 9:12 a.m., the resident was observed in bed. At the time, the bed was in a low position,	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** It is the policy of Miller's Health & Rehab La Porte to ensure adequate supervision is provided related to fall interventions. Resident #48 bed was lowered and fall mat put into place. Care plan updated that bed would be in higher position and no mat in place when visitors present in room. Visitors educated to inform staff when they are leaving. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers and other Administration completed walking rounds and assessed all fall interventions. Care plans and CNA assignment sheets reviewed and updated for accuracy. Both tasks were completed on or before June 14, 2024. All staff were educated to be vigilant when observing residents with fall risk. Nursing staff were re-educated on or before June 14, 2024 on the "Fall Management Procedure" policy and procedure.	06/14/2024

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	however, the floor mat was against the wall. The resident's spouse was seated in the chair by the head of the bed. On 5/20/24 at 11:45 a.m., the resident was observed in bed. At that time, the bed was in a very high position and the floor mat was against the wall and not beside the bed. The resident's spouse was seated in a chair by the window. The record for Resident 48 was reviewed on 5/20/24 at 9:16 a.m. Diagnoses included, but were not limited to, fracture T9-T10 (Thoracic spine) vertebra, anemia, Parkinson's disease, and high blood pressure. The 5/2/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had a limitation in range of motion to both upper and lower extremities and was dependent on staff for transfers and bed mobility. The resident had no history of falls and had unhealed pressure injuries. A Care Plan, initiated on 1/12/24, indicated the resident was at risk for falls due to Parkinson's disease and incontinence. Physician's Orders, dated 4/25/24, indicated place the bed in the lowest position and have a fall mat in place every shift for safety. During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing indicated the bed should be in the lowest position with the floor mat on the side of the bed while the resident was in bed. The Unit Manager spoke to the resident's spouse, who said she told staff to keep the bed in the high position while she was there so she did not have to look		(Attachment G). The DON or designee will be responsible to complete QA tool "Free of accident QA Review" 5x week x 4 weeks, weekly x4 weeks than 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 "Free of Accident QA Review" (ATTACHMENT H) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	155297	A. BUILDING 00 B. WING	05/22/2024

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	down at the resident. 3.1-45(a)(2)			
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, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate, for 2 of 3 residents reviewed for respiratory care (Residents 49 and 44) Findings include: 1. On 5/16/24 at 10:36 a.m., Resident 49 was observed sitting in a recliner chair in his room. At that time, he was wearing oxygen per nasal cannula and was connected to the room concentrator. The ball on the oxygen dial was all the way at the bottom of and well below 0.5 liters. On 5/17/24 at 8:59 a.m., the resident was observed wearing the oxygen and the ball on the oxygen dial was below the 0.5 liter mark. On 5/17/24 at 12:28 p.m., the resident was observed wearing the oxygen and the bottom of the ball on the dial was above the 0.5 liter mark.	F 0695	/b> **/b>** **/p>** **/p>** **/p>** **Resident #44: Resident suffered no negative outcomes. Oxygen will be administered at the ordered rate of flow per physician's order. HCP reviewed by the IDT and reflects oxygen use.** *All residents are at risk to be affected by the deficient practice*. The nurse managers completed an audit by 5//24 of all residents utilizing oxygen to ensure physician's order for use, that	06/14/2024

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	The record for Resident 49 was reviewed on 5/20/24 at 10:59 a.m. Diagnoses included, but were not limited to, fracture of left femur, COPD, heart failure, respiratory failure, type 2 diabetes, high blood pressure, and atrial fib. The 3/26/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident used oxygen while at the facility and received diuretic medication. A Care Plan, dated 5/17/24, indicated the resident had heart failure. The approaches were to provide oxygen as ordered. Physician's Orders, dated 3/19/24, indicated oxygen at 0.5 liters per minute per nasal cannula, continuously every shift. During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing indicated the oxygen should be set on 0.5 liters and ball should be centered in the middle of the line of the amount to be administered. 2. On 5/16/24 at 10:31 a.m., Resident 44 was observed lying in bed. She was wearing oxygen via nasal cannula and the flow rate was under the 3 liter line. On 5/16/24 at 11:22 a.m., the resident was observed sitting in her wheelchair. She was wearing oxygen via nasal cannula and the flow rate was set at just under the 3 liter line. On 5/17/24 at 11:11 a.m., the resident was observed not wearing oxygen. She had a portable tank attached to her wheelchair and the flow rate was on at 3 liters. The resident indicated she just had a bath and was taking an oxygen break for a moment.		oxygen is delivered at the correct ordered liter flow, and that oxygen is included in the resident's HCP. An all nursing staff in-service was held on or before 6/14/24 to review the "Oxygen Administration Protocol" (Attachment I). Charge nurses will be responsible to ensure that flow rates are set to ordered liter flow. The charge nurses will participate in routine walking rounds during tour of duty to monitor residents receive oxygen as ordered. The DON or other designee will be responsible to complete the QA tool titled "Respiratory Care" (Attachment J). The tool will be completed daily x5days, 3x weekly x 4 weeks, then weekly x 4weeks then monthly to monitor for ongoing compliance. Any identified issues will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days.	

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	On 5/20/24 at 11:34 a.m., the resident was sitting in her wheelchair and her oxygen was on and in place. The oxygen flow rate was on at 3 liters. On 5/20/24 at 1:25 p.m., the resident was observed in her recliner eating lunch. She was wearing oxygen via nasal cannula and the flow rate was on at 3 liters. The record for Resident 44 was reviewed on 5/17/24 at 1:07 p.m. The diagnoses included, but were not limited to, arthritis right shoulder, atrial fibrillation, aphasia, anemia, hypertension, obstructive uropathy, and high cholesterol. The Admission Minimum Data Set (MDS) assessment, dated 2/19/24, indicated the resident was cognitively intact for daily decision making. The resident required oxygen therapy. There was no oxygen care plan. A Physician's Order, dated 2/13/24, indicated to check the oxygen flow rate was on at 2 liters. A Nurses Note, dated 2/13/24 at 12:07 p.m., indicated the resident's oxygenation level on room air was 87% and 2 liters of oxygen was applied. A Nurses Note, dated 3/8/24 at 1:32 p.m., indicated the nasal cannula was secured and oxygen was on at 2 liters. The Treatment Administration Record (TAR) for May 2024 indicated oxygen was signed out as being administered at 2 Liters on the following dates: 5/16/24, 5/17/24, 5/18/24, 5/19/24, and 5/20/24.			

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	During an interview on 5/21/24 at 9:13 a.m., the Director of Nursing (DON) indicated she understood the concern regarding the resident's oxygen not being on at the correct rate and had no additional information to provide. 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure blood pressure and diuretic medications were not administered outside of their physician ordered parameters for 3 of 6 residents reviewed for unnecessary medications. (Residents 40, 49, and 6)	F 0757	**F757 Drug Regimen is free from unnecessary drugs** It is the policy of Miller's Health & Rehab La Porte to ensure blood pressure and diuretic medications are not administered outside of	06/14/2024

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	Findings include: 1. The record for Resident 40 was reviewed on 5/17/24 at 11:14 a.m. The resident was admitted to the facility on 4/17/24. Diagnoses included,but were not limited to, fractured ribs, Alzheimer's disease, high blood pressure, acute kidney failure, falls, type 2 diabetes, high blood pressure and anxiety. The 4/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Care Plan, dated 4/17/24, indicated the resident had chronic cardiovascular disease related to high blood pressure. The approaches were to administer medications as ordered. Physician's Orders, dated 4/30/24, indicated Clonidine (a medication used to reduce blood pressure) 0.1 milligrams (mg), give 1 tablet by mouth two times a day and hold if the systolic blood pressure (top number) was less than 140. Physician's Orders, dated 5/2/24, indicated Hydralazine (a medication used to reduce blood pressure) 50 mg, give 1 tablet by mouth every 6 hours and hold if the systolic blood pressure was less than 160. Physician's Orders, dated 5/6/24, indicated Metoprolol Tartrate (a medication to lower the heart rate and blood pressure) 50 mg, give 1 tablet by mouth two times a day and hold if the systolic blood pressure was less than 140 and pulse was less than 60. The 4/2024 and the 5/2024 Medication		physician ordered parameters. Resident #40 no longer resides at the facility. Resident #49 no longer resides at the facility. Resident #6 No longer at facility All residents residing in the facility have the potential to be affected by the deficient practice. The nurse managers will complete an audit of facility diuretic and blood pressure orders by 5//24 to ensure parameters for administration are followed administered per physician's order. An all licensed nursing/QMA in-service will be completed on or before 6/14/24 to review the facility policy on following physician's orders and ensuring that medications are administered as ordered. (Attachment K). Nursing will be responsible to follow ordered parameters and documenting the findings in the EMR. Nurse managers participate in routine audits of the facility MAR/TAR's and will review blood pressure, diuretic and other medications with resident specific parameters to ensure administration occurs as ordered. The DON or designee will be responsible to complete the QA tool "Unnecessary Drugs QA Review" 5x week x 4 weeks, weekly x4 weeks than monthly x3 months, and quarterly thereafter. This will be reviewed in the facility	

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	Administration Record (MAR) indicated the Clonidine was administered on 5/15/24 (p.m.) dose with a blood pressure of 111/58. The Hydralazine was administered on the following days and times against ordered parameters: - 5/9/24 11 a.m. dose with a blood pressure of 98/52 - 5/13/24 5 p.m. dose with a blood pressure of 136/60 - 5/7/24 11 p.m. dose with a blood pressure of 155/76 - The Hydralazine was held on 5/10/24 at the 5 a.m. dose with a blood pressure of 164/80 The Metoprolol was administered on the following days and times against ordered parameters: - 4/30/24 the 9 p.m. dose with a pulse of 49 - 5/13/24 9 a.m. dose with a blood pressure of 149/70 - 5/14/23 9 p.m. dose with a blood pressure of 159/66 - 5/18/24 with a pulse of 57 - The Metoprolol was held on 5/8/24 at 9 a.m. with a blood pressure of 145/68. During an interview on 5/21/24 at 1:05 p.m., the Director of Nursing indicated the blood pressure medication should have been given as ordered by the physician. 2. The record for Resident 49 was reviewed on 5/20/24 at 10:59 a.m. Diagnoses included, but were not limited to, fracture of left femur, COPD, heart failure, respiratory failure, type 2 diabetes, high blood pressure, and atrial fib. The 3/26/24 Admission Minimum Data Set (MDS)		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 “Unnecessary Drugs QA Review” (ATTACHMENT L) specifically monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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	assessment indicated the resident was cognitively intact for daily decision making. The resident used oxygen while at the facility and received diuretic medication. A Care Plan, dated 5/17/24, indicated the resident had heart failure. The approaches were to administer medication as ordered. Physician's Orders, dated 4/21/24, indicated the following: - Furosemide (a diuretic medication) 40 milligrams (mg), give 1 tablet by mouth two times a day for edema and hold if systolic blood pressure was less than 140. - Aldactone (a diuretic medication) 25 mg, give 1 tablet by mouth two times a day for edema and hold if systolic blood pressure was less than 140. The 4/2024 and 5/2024 Medication Administration Records (MAR) indicated the Furosemide and the Aldactone were administered on 4/29/24 for the a.m. dose with a blood pressure of 138/72. They both were administered on 4/29/24 for the p.m. dose with a blood pressure of 133/74. The Aldactone and the Furosemide were administered on 5/4/24 for the a.m. dose with a blood pressure of 136/85 and the Furosemide was administered on 5/1/24 for the a.m. dose with a blood pressure of 112/64. During an interview on 5/21/24 at 1:05 p.m., the Director of Nursing indicated the diuretic medications should have been administered as ordered by the physician.3. The record for Resident 6 was reviewed on 5/20/24 at 3:42 p.m. The diagnoses included, but were not limited to, heart failure, depression, kidney disease, and cellulitis of right leg.			

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	The Significant Change Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 3/23/24, indicated to administer Losartan Potassium tablet 100 milligrams (mg) daily. The medication was to be held if the resident's systolic blood pressure was less than 120. The Medication Administration Records (MAR) for March - May 2024 indicated the Losartan was signed out as given with the blood pressure less than 120 systolic on the following dates: - 3/21/24 with a blood pressure of 119/73. - 4/19/24 with a blood pressure of 97/78. - 5/9/24 with a blood pressure of 110/70. The resident's blood pressure was not documented on the Medication Administration Record (MAR) for the months of 10/2023, 11/2023, 12/2023, and 1/2024, nor was the resident's blood pressure documented in the vitals section of the electronic medical record on a consistent basis. During an interview on 5/21/24 at 11:39 a.m., the Director of Nursing (DON) indicated she understood the concern regarding the medication was administered outside of the ordered parameters and no additional information was provided. 3.1-48(a)(3) 3.1-48(a)(4)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.			

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	(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard			

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	medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to a resident's temperature on the Infection Control Assessment for 1 of 1 residents reviewed for urinary tract and respiratory infections, completed meal consumption and monitoring intake of nutritional supplements for 1 of 1 residents reviewed for nutrition, discontinuing pressure injury treatments for 1 of 2 residents reviewed for pressure ulcers, and the documentation of oxygen when not in use for 1 of 3 residents reviewed for oxygen therapy. (Residents 25, 40, 48 and 11)	F 0842	**F 842 Resident Records – Identifiable Information** It is the policy of Miller's Health & Rehab La Porte to ensure clinical records are complete and accurately documented for temperatures, meal consumption of nutritional supplements, discontinued pressure injury treatments and oxygen therapy not in use. Resident #25 there was no adverse or harm to resident. Resident #40 no longer resides at facility.	06/14/2024

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	Findings include: 1. The record for Resident 25 was reviewed on 5/20/24 at 2:02 p.m. Diagnoses included, but were not limited to, obstructive uropathy, urine retention, high blood pressure, chronic kidney disease, stroke, and Alzheimer's dementia. The 5/1/24 Admission minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident was not receiving antibiotics for any infection. There was no Care Plan for antibiotic therapy. Physician's Orders, dated 5/12/24, indicated Amoxicillin-Pot Clavulanate (an antibiotic medication) 875-125 milligrams (mg), give 1 tablet by mouth every 12 hours for Atelectasis (occurs when the small sacs in the lungs (alveoli) can't inflate properly, leading to a partial or full collapse of the lungs) for 10 days. Physician's Orders, dated 5/14/24, indicated Cipro 500 mg (an antibiotic medication) give 1 tablet by mouth two times a day for an Urinary Tract Infection for 7 days. A Nursing Infection Assessment, dated 5/15/24 at 2:06 p.m., indicated the resident's temperature documented was from 5/14/24 at 10:45 a.m. A Nursing Infection Assessment, dated 5/19/24 at 9:45 a.m., , indicated the resident's temperature documented was from 5/18/24 at 7:40 p.m. During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing indicated the Nursing Infection Assessment was completed daily on the evening shift while the resident was receiving		Resident #48 treatment was discontinued out MAR. Resident #11 oxygen was discontinued. All residents residing in the facility have the potential to be affected by the deficient practice. Nurse managers audited oxygen orders, nutritional supplement orders, infection assessments V/S and wound treatment orders for accuracy on or before 6/14/2024. All licensed nursing staff and QMA's were educated on or before June 14, 2024 on "Charting procedure, Nutritional oral supplements, order entry, discounting orders and entering current vital signs when documenting Infection Assessments. (Attachment M) The DON or designee will be responsible to complete the QA tool "Resident Records QA Review" 5x week x 4 weeks, weekly x4 weeks than 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 "Resident Records QA Review" (ATTACHMENT N) specifically	

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	155297	A. BUILDING 00 B. WING	05/22/2024

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	antibiotics and the resident's temperature should be checked at the time the assessment was completed. 2. During a random observation on 5/20/22 at 12:10 p.m., the Resident 40 received her lunch meal. At that time, she was served a 4 ounce glass of a thick white substance. The record for Resident 40 was reviewed on 5/17/24 at 11:14 a.m. The resident was admitted to the facility on 4/17/24. Diagnoses included,but were not limited to, fractured ribs, Alzheimer's disease, high blood pressure, acute kidney failure, falls, type 2 diabetes, high blood pressure and anxiety. The 4/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident's current weight on 5/13/24 was 101 pounds. The resident weighed 110 pounds on admission (4/17/24) which was a significant weight loss. The meal consumption in the last 30 days indicated the breakfast meal was not documented on 4/19, 4/23, 4/25, and 5/10/24. The lunch meal was not documented on 4/24 and 4/25/24 and the dinner meal was not documented on 4/18/24. A Nurses' Note, dated 5/16/24 at 12:14 p.m., indicated the IDT (Interdisciplinary Team) met to discuss the resident's current weight loss. The Dietary manager recommended 4 ounce sugar free healthshake three times a day with meals and monitor weekly weights. The Physician was notified and in agreement. A new order was received for sugar free healthshake with meals.		monitoring care plan accuracy and revision. Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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There was no Physician's Order for the healthshake. There was no documentation of how much of the healthshake the resident consumed.

During an interview on 5/21/24 at 8:45 a.m., the Director of Nursing (DON) indicated all health shakes were poured into a glass and not in individual cartons. The amount consumed after each meal should be documented on the Enteral/Supplement Administration Record and meal consumption should be documented after each meal.

The current 8/23/23 "Wound, Weight, and Hydration Meeting" policy, provided by the DON on 5/21/24 at 1:47 p.m., indicated the Dietary Manager should review the menus online during the meeting to ensure supplements or food add-ons were included on the menu or added to the menu. The task list on the POC (computerized charting) would be monitored during the meeting to ensure house shakes were being documented along with intakes.

3. The record for Resident 48 was reviewed on 5/20/24 at 9:16 a.m. Diagnoses included, but were not limited to, fracture T9-T10 (Thoracic spine) vertebra, anemia, Parkinson's disease, and high blood pressure.

The 5/2/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had a limitation in range of motion to both upper and lower extremities and was dependent on staff for transfers and bed mobility. The resident had no history of falls and had unhealed pressure injuries.

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	A Care Plan, dated 1/12/24, indicated the resident was admitted with a wound that was caused by wearing a back brace. Physician's Orders, dated 3/20/24, indicated Santyl Ointment 250 units/grams, apply to upper back wound topically every day shift and cover with 6 by 6 bordered foam dressing. Physician's Orders, dated 5/8/24, indicated cleanse wound with normal saline and apply dermasyn AG gel to the wound bed and cover with 4 by 4 bordered foam dressing. The order was discontinued on 5/16/24. The Treatment Administration Record (TAR), dated 5/2024, indicated the Santyl was signed out as being completed 5/1-5/17/24. The dermasyn AG gel was also signed out as being completed 5/9-5/16/24. Both treatments were signed out as being done at the same time. During an interview on 5/21/24 at 1:05 p.m., the Director of Nursing indicated, from 5/9-5/16/24, the treatment to the wound was the dermasyn AG gel and not the Santyl. The Wound Nurse forgot to discontinue the Santyl. 4. On 5/16/24 at 10:39 a.m., Resident 1 was observed not wearing any oxygen, there was an oxygen concentrator and tubing against the wall that was turned off. The resident indicated they were no longer using it. On 5/16/24 at 12:20 p.m., the resident was observed sitting in her wheelchair in the dining area for lunch. The resident was not wearing any oxygen. There was an order in the chart for continuous oxygen use at 2 liters. On 5/17/24 at 11:12 a.m., the resident was observed sitting in her wheelchair. She was not			

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	wearing any oxygen. The concentrator and tubing were placed against the wall. On 5/20/24 at 11:36 p.m., the resident was observed sitting in her wheelchair, she was not wearing any oxygen. The oxygen tank was off and stored against the wall. The resident indicated she no longer used the oxygen. The record for Resident 11 was reviewed on 5/17/24 at 2:14 p.m. The diagnoses included, but were not limited to, kidney failure, cellulitis of the lower leg, diabetes, respiratory failure, dementia, bipolar disorder, heart failure, sleep disorder, dysphagia (difficulty swallowing), depression, difficulty walking, hypertension (high blood pressure), and anxiety. The Significant Change Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident was cognitively intact for daily decision making and she required oxygen therapy. A Physician's Order, dated 5/9/24, indicated to administer oxygen at 2 liters via nasal cannula every shift. The May 2024 Medication Administration Record (MAR) indicated the resident's oxygen was signed out as being administered on the following dates: 5/16/24, 5/17/24, 5/18/24, 5/19/24 and 5/20/24. During an interview on 5/21/24 at 9:13 a.m., the Director of Nursing (DON) indicated she understood the concern regarding Resident 11's oxygen being signed out as given and had no additional information to provide. 3.1-50(a)(1)			

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	3.1-50(a)(2)			