10/27/2022 PRINTED: FORM APPROVED 039

PARTMENT OF BEALTH AND BUT	VIAN SERVICES		FORM AFFRO
NTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 0938-
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	455557	D WING	40/40/0000

155557 10/18/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1651 N CAMPBELL ST MILLER'S MERRY MANOR INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0000 Bldg. 00 This visit was for the Investigation of Complaint F 0000 Please accept this survey POC as IN00391853. the providers credible allegation of compliance with a completion date Complaint IN00391853 - Substantiated. of 10/19/2022. Federal/state deficiencies related to the allegations are cited at F692 Survey dates: October 17 and 18, 2022 Facility number: 000500 Provider number: 155557 AIM number: 100266220 Census Bed Type: SNF/NF: 58 SNF: 7 Total: 65 Census Payor Type: Medicare: 5 Medicaid: 48 Other: 12 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 20, 2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nutrition/Hydration Status Maintenance

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the

TITLE

(X6) DATE

Any defiency statement 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.

Event ID: E2SH11 000500 Page 1 of 6 Facility ID: If continuation sheet

483.25(g)(1)-(3)

F 0692

SS=D

Bldg. 00

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155557 B. WING 10/18/2022 STREET ADDRESS, CITY, STATE, ZIP COD

	PROVIDER OR SUPPLIER  'S MERRY MANOR	1651 N	1651 N CAMPBELL ST INDIANAPOLIS, IN 46218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  facility must ensure that a resident-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;  §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;  §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure a resident was provided nutritional supplements as ordered for 1 of 3 residents reviewed for weight loss. (Resident C)  Findings include:  The clinical record for Resident C was reviewed on 10/17/22 at 11 a.m. Resident C's diagnoses included, but not limited to, diabetes type II, ulcer of esophagus, intellectual disabilities, hypertension, and gastro-esophageal reflux disease (GERD) with esophagitis.  Resident C's quarterly MDS (Minimum Data Set) dated 9/5/22 indicated, he required extensive assistance of two persons for bed mobility, transfers, and bathing; and extensive assistance of one person for eating.  A physician's order dated 3/8/22 indicated, Resident C's diet was a pureed diet.	F 0692	F692 Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident C had supplements reviewed by the IDT including the RD and recommendations were changed on 10/18/2022 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?  All residents residing in the facility have the potential to be affected by the alleged deficient practice  An audit of all residents was completed on 10/19/2022 ensuring that all residents were reviewed to determine if interventions remain	10/19/2022	

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DEPARTMENT	Γ OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED	
CENTERS FOR	R MEDICARE & MEDIC					OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í	(X2) MULTIPLE CONSTRUCTION			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
	155557 B. WING					10/18/	10/18/2022	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					I CAMPBELL ST			
MILLER'S	S MERRY MANOR			INDIAN	NAPOLIS, IN 46218			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
	A physician's order	dated 2/9/22 indicated,			appropriate.			
	Resident C was to h	nave a diet supplement of						
	"Magic Cup" every	evening shift for weight loss.			What measures will be put in	to		
					place or what systemic			
	A physician's order				changes you will make to			
		/6/22 indicated, Resident C was			ensure that the deficient			
		ement of Ensure plus three			practice does not recur?			
	times a day.				<ul> <li>All nursing staff educated or before 10/19/2022 on the</li> </ul>	d on		
A physician's order dated 10/6/22 indicated, Resident C was to have a diet supplement of Ensure plus four times a day.  Resident C's September and October enteral and								
				"Weight Management" policy a	and			
				procedure (Attachment A).				
				How the corrective action(s)	_			
				will be monitored to ensure t	he			
	_				deficient practice will not			
		ministration record were			recur, i.e., what quality			
		22 at 12:19 p.m. The rd indicated, on the following			assurance program will be p	ut		
		esident C had not received his			into place?  Any identified trends will be			
		ments and/or Magic Cup			corrected upon discovery,			
	supplement:	ments and/or wagie Cup			documented on facility QA			
	Ensure Plus:				tracking log and reported during	าต		
	9/1/22morning, m	nid-day, evening			monthly QA Committee meeting	•		
	9/2/22morning, m				overseen by the Executive Dir	_		
	9/5/22morning an				·The QA tool "Nutrition QA			
	9/6/22morning, m	_			Review"(Attachment B) will be			
	9/8/22morning, m				utilized 5x week x 4 weeks,			
	9/9/22morning, m	nid-day, evening			monthly x3 months, and quarte	erly		
	9/12/22morning, 1	mid-day, evening			thereafter. This will be review	ed in		
	9/13/22-morning, n	-			the facility Quality Assurance	&		
	9/14/22morning a				Performance Improvement (Q.	API)		
	9/15/22morning, 1	•			meeting. The facility will do so	o to		
	9/16/22morning a	-			ensure ongoing compliance fo			
	9/19/22morning, 1	-			minimum 6 months and until the			
	9/20/22morning, 1	-			facility maintains 95% complia			
	9/22/22morning, 1	mid-day, evening			for 60days thereafter as part of	f the		

9/23/22--morning, mid-day, evening

9/26/22--morning, mid-day, evening 9/27/22--morning, mid-day, evening 9/28/22--morning and mid-day 9/29/22--morning, mid-day, evening

QA program.

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039 (X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C	CONSTRUCTION			
		A. BUILDING	00	COMPI		
		155557	B. WING	_	10/18	/2022
NAME OF I	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP COD		
				N CAMPBELL ST		
MILLER	S MERRY MANOR		INDIAI	NAPOLIS, IN 46218		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	10/4/22morning a 10/7/2211 p.m.	ind mid-day				
	10/8/226 a.m. and	l 11 n.m.				
	10/9/226 a.m. and	-				
	10/10/226 a.m.	•				
	10/11/225 p.m.					
	10/12/225 p.m. ar					
	10/13/226 a.m. ar	-				
	10/14/2211 a.m.,					
	10/15/226 a.m. ar 10/16/226 a.m. ar					
	10/16/226 a.m. ar	id 11 p.m.				
	Magic cup:					
	9/1/22					
	9/2/22					
	9/6/22					
	9/8/22					
	9/9/22					
	9/12/22					
	9/13/22					
	9/15/22 9/19/22					
	9/20/22					
	9/22/22					
	9/23/22					
	9/26/22					
	9/27/22					
	9/29/22					
	10/10/22					
	10/11/22					
	10/12/22					
	10/13/22 10/14/22					
	10/14/22					
	An observation of I	Resident C in the dining room				
		e was conducted on 10/17/22				
	_	dining room was very noisy and				

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Resident C was in his Broda chair at a table. Resident C had consumed his house shakes, the magic cup remained unopened, and only bites of

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 155557  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218  STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION food were consumed. There was no evidence of an Ensure Plus supplement given at lunch meal.  An interview with Dietary Manager (DM) was conducted on 10/17/22 at 2:59 p.m. She indicated, the magic cups are distributed to the units and kept in the unit refrigerators for the evening shift and the Ensure Plus supplements were in the unit refrigerators and were to be distributed by the nursing staff when needed. She further indicated, the facility had not experienced any issues with obtaining an adequate supply of Magic cups or Ensure Plus.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  food were consumed. There was no evidence of an Ensure Plus supplement given at lunch meal.  An interview with Dietary Manager (DM) was conducted on 10/17/22 at 2:59 p.m. She indicated, the magic cups are distributed to the units and kept in the unit refrigerators and were to be distributed by the nursing staff when needed. She further indicated, the facility had not experienced any issues with obtaining an adequate supply of Magic cups or Ensure Plus.  STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218  (X5) PREFIX PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218  (X5) COMPLETION DATE  COMPLETION DATE			A. BU	A. BUILDING <u>00</u>				
MILLER'S MERRY MANOR  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  food were consumed. There was no evidence of an Ensure Plus supplement given at lunch meal.  An interview with Dietary Manager (DM) was conducted on 10/17/22 at 2:59 p.m. She indicated, the magic cups are distributed to the units and kept in the unit refrigerators for the evening shift and the Ensure Plus supplements were in the unit refrigerators and were to be distributed by the nursing staff when needed. She further indicated, the facility had not experienced any issues with obtaining an adequate supply of Magic cups or Ensure Plus.			155557	B. WI	B. WING 10/18/2			/2022
MILLER'S MERRY MANOR  (X4) ID  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  food were consumed. There was no evidence of an Ensure Plus supplement given at lunch meal.  An interview with Dietary Manager (DM) was conducted on 10/17/22 at 2:59 p.m. She indicated, the magic cups are distributed to the units and kept in the unit refrigerators for the evening shift and the Ensure Plus supplements were in the unit refrigerators and were to be distributed by the nursing staff when needed. She further indicated, the facility had not experienced any issues with obtaining an adequate supply of Magic cups or Ensure Plus.  (X5)  COMPLETION  PREFIX TAG  PROVIDERS PLAN OF CORRECTION SHOULD BE PREFIX TAG  PROVIDERS PLAN OF CORRECTION  (EACH DEPICIENCY)  COMPLETION  DATE  (X5)  COMPLETION  DATE  OF THE ACT OF CORRECTION SHOULD BE PREFIX TAG  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY)  COMPLETION  DATE  OF THE ACT OF CORRECTION SHOULD BE PREFIX TAG  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY)  COMPLETION  DATE  OF THE ACT OF CORRECTION SHOULD BE PREFIX TAG  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY)  COMPLETION  DATE  OF THE ACT OF CORRECTION SHOULD BE PREFIX TAG  PROVIDERS PLAN OF CORRECTION SHOULD BE PROVIDED SHOULD BE PREFIX TAG  PROVIDERS PLAN OF CORRECTION	NAME OF P	DROWNER OF CURRY TER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (PROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)  food were consumed. There was no evidence of an Ensure Plus supplement given at lunch meal.  An interview with Dietary Manager (DM) was conducted on 10/17/22 at 2:59 p.m. She indicated, the magic cups are distributed to the units and kept in the unit refrigerators for the evening shift and the Ensure Plus supplements were in the unit refrigerators and were to be distributed by the nursing staff when needed. She further indicated, the facility had not experienced any issues with obtaining an adequate supply of Magic cups or Ensure Plus.	MILLER'S	S MERRY MANOR			INDIAN	APOLIS, IN 46218		
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obtaining an adequate supply of Magic cups or Ensure Plus.		_						
Ensure Plus.		-	-					
			ate supply of Magic cups of					
		Elisare Tras.						
Resident C's clinical record indicated, his weights		Resident C's clinica	al record indicated, his weights					
were:								
6/8/2267.6 pounds		6/8/2267.6 pounds	s					
7/2/2260.5 pounds		_	s					
8/1/2264 pounds		_						
9/5/2260.6 pounds		_						
10/6/2259 pounds		10/6/2259 pounds						
A RD (Registered Dietician) narrative note dated		A RD (Registered I	Dietician) narrative note dated					
9/22/22 at 2:09 p.m. indicated, Resident C had a		` •						
weight loss of 5.3% in 30 days and 10.4% in 90		_						
		days. His intake was less than 50% of most meals on regular diet. His nutrition interventions included, but not limited to, super pudding at lunch and supper, 8 ounces of house supplement at meals, Ensure plus three times a day and Magic cup every evening shift. Under additional comments, it indicated, "[Resident C's name] sometimes stops eating when distracted by noises and his is a picky eater who drinks better than he						
**								
and his is a picky eater who drinks better than he								
eats." The plan of action was changes were								
recommended which included, but not limited to,		recommended which	h included, but not limited to,					
suggest trial locations for Resident C's meals to								
determine the environment in which he ate best.		determine the envir	onment in which he ate best.					
A RD narrative note dated 10/5/22 at 11:04 a.m.		A RD narrative note	e dated 10/5/22 at 11:04 a.m.					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	THE PROPERTY OF THE PARTY OF TH	- HD SERVICES			ONID 110: 0200 002	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	00	COMPLETED	
		155557	B. WING		10/18/2022	
	ROVIDER OR SUPPLIER	2	1651 N	ADDRESS, CITY, STATE, ZIP COD I CAMPBELL ST JAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	indicated, Resident	C had a stage 2 pressure				
	injury to inner left of	elbow, his weight loss was				
	5.3% in 30 days and	d 10.4% in 90 days.				
	Recommendations	included, but not limited to,				
	offer additional supplement of Ensure Plus when					
	he was awake durin	g the night.				
	received on 10/17/2 (Director of Nursin "Alternative will be consumed at meals palliative care resid IDT[sic, interdiscip the continued beneficially weights"	nent Program policy was 22 at 3:13 p.m. from DON g). The policy indicated, a offered if less than 50% isHospice residents and/or ents shall be assessed by the dinary team] team to determine fit for obtaining routine ates to complaint IN00391853.				

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