STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155574	A. BUILDING 00 B. WING	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

(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, 12, and 12, 2024 Facility number: 000431 Provider number: 155574 AIM number: 100290380 Census Bed Type: SNF: 5 SNF/NF: 36 Total: 41 Census Payor Type: Medicare: 5 Medicaid: 29 Other: 7 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/21/24.	F 0000	Please accept the attached plan of correction as a credible allegation of compliance to the deficiencies cited curing our Annual Survey conducted on January 8-12, 2024. Hopefully you will find the remedies sufficient, thoroughly explained, and able to provide a clear picture of how we corrected the concerns. With this submission of these remedies, we are respectfully requesting paper compliance. If after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at 574-586-3133. Christy Clark, Administrator	
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			

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

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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	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)- (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 record review and interview, the facility failed to develop a comprehensive care plan for a	F 0656	It is the policy of Miller's Merry Manor to develop and implement	02/02/2024

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	resident with depression for 1 of 19 residents reviewed for comprehensive care plan development. (Resident 34) Finding includes: A record review for Resident 34 was completed on 1/9/2024 at 2:21 P.M. Resident 34's diagnoses included, but were not limited to: depression and cerebral infarction. Resident 34's record lacked the documentation to show she had a care plan for depression. An interview with the Social Services Director (SSD) was completed on 1/11/2024 at 10:10 A.M. The SSD indicated that Resident 34 didn't have a care plan for depression, but should have had a care plan for depression. On 1/11/2024 at 3:00 P.M., the Director of Nursing (DON) provided a policy, dated 1/24/2020 and titled, "Care Plan Development and Review". The DON indicated that the policy was the one currently used by the facility. The policy indicated, "...2. Care Plan Development: A. An interdisciplinary team, in conjunction with the resident, physician and representative will develop a comprehensive care plan for each resident...." 3.1-35(a)		resident-centered care plans for all residents. Resident #34 was successfully discharged to home on 1/10/2024. All residents have the potential to be affected by the deficient practice. All residents on psychoactive medications were reviewed to ensure all conditions and need for medication was care planned on 1/29/24. To ensure care plans are accurate and complete, all new orders are reviewed as part of the daily clinical meeting to ensure new orders have been added to the care plan. Diagnosis will be reviewed to ensure those with active treatment plans are included on the resident's care plan. In addition, nurses are being re-educated on care plan development and revision with new orders and condition changes January 25 and February 1, 2024. (Attachment D). To ensure continued compliance, the audit tool "Care Plan Development and Revision" (Attachment A) will be completed daily times 5 weeks, weekly time 2 weeks, then monthly times 2 months.	

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			Findings will be reported in the monthly QAPI meeting to determine if a change in plan is warranted and determine frequency and duration of continued audits once above frequency is completed.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			

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	Based on interview and record review, the facility failed to update a fall care plan with a new interventions after a fall for 1 of 2 resident reviewed for falls. (Resident 27) Finding includes: During an interview on 1/8/2024 at 2:00 P.M., Resident 27 indicated he had a fall but was unsure of the date. A record review was completed on 1/11/2024 at 9:00 A.M. Diagnoses included, but were not limited to: heart failure, presence of left artificial hip, and difficulty walking. An MDS (Minimum Data Set) assessment, dated 12/22/2023, indicated Resident 27 had intact cognition, transferred with supervision of one staff assist, toileting with supervision of one staff assist, independent with walking and walker. A Care Plan, dated 1/19/2022, indicated Resident 27 was at risk for falls related to condition and risk factors and required the use of assistive devices. Interventions included but were not limited to: encourage to use call light and wait for staff to assist as needed, although likes to toilet self, encourage resident to use handrails or assistive devices properly, encourage and assist with wearing non-skid footwear. Interdisciplinary Notes, dated 12/3/2023, indicated Resident 27 was in the bathroom and his knee buckled, Resident 27 guided himself to the floor by grabbing hold of the towel bar, Nursing assessment was completed with no injury. A Nurse Practitioner's Progress Note, dated 12/5/2023, indicated Resident 27 had been	F 0657	It is the policy of Miller's Merry Manor to update or revise resident care plans as resident's condition or treatment changes. Resident #27's HCP is current with appropriate fall prevention intervention, updated 1/25/24 All residents have the potential to be affected by this deficient practice. Fall Management Policy was reviewed with nurse managers during an in service on 1/25/2024 and 2/1/2024 to include fall investigation, root cause analysis and development of a preventative intervention initiated, and added to the care plan. (Attachment D) Fall investigations will be reviewed in the daily clinical meeting to determine root cause and develop preventative interventions to be added to the care plan and nurse aide assignment sheets if appropriate. To ensure continued compliance, the audit tool, "Care Plan Development and Revision Survey Audit #1" (Attachment A) will be completed daily times 5 days, weekly times 2 weeks, then monthly times 2 months. Findings will be reported in the monthly QAPI meeting to	02/02/2024

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	evaluated by the Nurse Practitioner and indicated Resident 27 had a ground level fall without injury on 12/3/2023. Physical therapy was ordered, and a flat mat at bedside and toilet for foot stability should have been considered. During an interview on 1/12/2024 at 9:23 A.M., the MDS Coordinator indicated she was unaware of the Nurse Practitioner Progress note, dated 12/5/2023, indicating the consideration of using mats for foot stability for Resident 27. She indicated the fall care plan should have been updated then. On 1/11/2024 at 3:00 P.M., the Director of Nursing provided a policy titled, "Care Plan Development and Review", dated 1/24/2020, and indicated the policy as the one currently used by the facility. The policy indicated " ...3. Care plans with be revised daily and as needed as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician Orders, diet changes, therapy changes, behavior changes, ADL [Activities of Daily Living] changes, skin changes, etc. ...." 3.1-35(c)(1)		determine if a change in plan is warranted and determine frequency and duration of continued audits once above frequency is completed.	
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.			

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	Based on observations, record reviews, and interviews, the facility failed to notify the physician of blood sugars out of the ordered range for 1 of 5 residents reviewed for unnecessary medications and failed to follow physician orders for a resident at risk for skin breakdown for 1 of 1 resident reviewed for edema. (Residents 28 & 10) Findings include: 1. A record review for Resident 28 was completed on 1/9/2024 at 2:09 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and unspecified dementia. Physician's Orders included the following: - 9/24/2023, check blood sugar three times a day, and notify the physician of a blood sugar less than 60 or greater than 400. - 9/30/2023, give Novolog Injection Solution, inject 5 units subcutaneously three times a day for a blood sugar greater than 150. - 11/23/2023-12/27/2023, give Lantus 100 units per milliliter, inject 10 units subcutaneously daily A blood sugar review indicated the following: - 12/2/2023 11:09 A.M. 435 - 12/4/2023 4:10 P.M. 401 - 12/6/2023 11:45 A.M. 467 - 12/13/2023 12:15 P.M. 503 - 12/15/2023 11:15 A.M. 445 - 12/16/23 11:13 A.M. 431 - 12/20/2023 11:32 A.M. 433 - 12/20/23 4:01 P.M. 432 - 12/23/2023 10:40 A.M. 423 - 12/25/2023 11:27 A.M. 431 - 12/28/2023 4:22 P.M. 455 During an interview on 1/11/2024 at 11:30 A.M.,	F 0684	It is the policy of Miller's Merry Manor to provide treatment and care in accordance with professional standards of practice. All residents are at risk to be affected by this deficient practice. Resident #28 has been discharged. Her attending physician was notified on 1/25/24 of blood sugars outside of the ordered range in the past 60 days. Nurses were re-educated on 1/25/24 and 2/1/2024 on following physicians orders, reporting blood sugars outside ordered parameters, and application and removal of hose, heel boots, splints, etc. (Attachment D) Nurse aides were re-educated on 1/30/2024 on application and removal of heel boots, TED hose and splints as indicated on nurse aide assignment sheets. (Attachment E) All diabetic residents with blood sugar orders were reviewed to ensure physician notification was made for readings outside parameters. All residents with boot, splint and TED hose orders were reviewed to ensure inclusion on nurse aide sheets and treatment records.	02/02/2024

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	QMA 2 indicated a blood sugar over 400, unless otherwise stated in the chart would be reported the physician. In her capacity, she would report the blood sugar to the nurse so the physician could be notified for an extra one-time dose of insulin. On 1/11/2024 at 1:17 P.M., the Director of Nursing (DON) indicated the Physician's Order would indicate when the physician would want to be notified for blood sugar readings. The DON reviewed Resident 28's orders, and indicated that a blood sugar reading over 400 should be reported to the physician. The DON reviewed the medical record, and could not find documentation of the physician being notified of the blood sugars over 400 listed above. She indicated the physician should have been notified of the blood sugars greater than 400. A policy was provided by the Director of Nursing on 1/12/2024 at 8:45 A.M. The policy titled, "Diabetic Care Guidelines", indicated, " ...Physician notification for all blood sugars < [less than] 50 and > [greater than] 400, unless other physician call parameters are in place ...."2. During an observation on 1/8/2024 at 1:45 P.M., Resident 10 was in bed and was not wearing heel protector boots on either foot. Resident 10's record review was completed on 1/9/2024 at 10:24 A.M. Diagnoses included, but were not limited to: seizures, dementia, depression, chronic kidney disease, and spondylosis of cervical region. An Annual Minimum Data Set (MDS) assessment, dated 10/26/2023, indicated Resident 10 had intact cognition and was dependent on staff for putting on and removing footwear.		To ensure continued compliance, the Audit Tool, "Quality of Care, Survey Audit #2" (Attachment B) will be completed daily times 5 days, weekly times 2 weeks, and monthly times 2 months. Findings will be reported in the monthly QAPI meeting to determine if a change in plan is warranted and determine frequency and duration of audits once above frequency is completed.	

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	A Physician's Order, dated 11/1/2023, indicated to wear heel protector boots while in bed. During an observation on 1/9/2024 at 1:24 P.M., Resident 10 was in bed and was not wearing heel protector boots. During an observation on 1/10/2024 at 1:40 P.M., Resident 10 was in bed and was not wearing heel protector boots. During an interview on 1/10/2024 at 2:23 P.M., The ADON indicated Resident 10 was not wearing heel protector boots while in bed, but should be wearing heel protector boots as ordered. A policy for following Physician's Orders was requested, but the ADON indicated the facility did not have a policy for following Physician's Orders. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, record review, and interview, the facility failed to implement measures to prevent pressure areas for 1 of 1 residents reviewed for pressure ulcers. (Resident 36) Finding includes: During an interview on 1/8/2024 at 10:31 A.M., Resident 36 indicated he had an open area to his bottom. A record review was completed on 1/8/2024 at 10:45 A.M. Resident 36's diagnoses included, but were not limited to depression, hyperglycemia, hypertension, and benign prostatic hyperplasia. A Patient Transfer Nurse Assessment- Extended Care from [name of hospital], dated 12/12/2023, indicated Resident 36 was alert and oriented, was ambulatory with 1 assist, was incontinent of urine and had erythema (superficial reddening) of the skin on his coccyx area. An Admission MDS (Minimum Data Set) assessment, dated 12/19/2023, indicated the resident was able to make his own decisions, required maximum assist to roll side to side, total dependence for transfers, was always incontinent and had no pressure ulcers on admission. A Nursing Admission Assessment, dated 12/12/2023, indicated Resident 36 was alert and oriented, had no edema to the lower extremities, left hemiplegia with maximum to total assist with bed mobility. Lower extremities have the following pressure prevention in place: Pressure relieving boots. Sit to lying: substantial/maximal assist. Pedal pulses present right and left feet. A Nursing Braden Scale (Assessment for Pressure	F 0686	It is the policy of Miller's Merry Manor to implement measures to prevent pressure ulcers. All residents are at risk for this deficient practice. Resident #36 suffers from Long Covid and continues to have lingering effects with multiple body systems. Resident #36 has been discharged, return not anticipated. Presently, all residents (2) on low air loss mattresses were checked on 1/24/24 and each has a flat sheet in place. Nursing assistants were re-educated on turning and repositioning residents on 1/30/24 (Attachment E). Nurses were re-educated on pressure ulcer risks and proper use of low air loss mattress and bedding on 1/25/24 and 2/1/2024. (Attachment D) The audit tool "Quality of Care Survey Audit #2" (Attachment B) will be completed daily times 5 days, weekly times 2 weeks, monthly times 2 months. Findings will be reported in monthly QAPI meeting to	02/02/2024

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	Risk), dated 12/12/2023, indicated Resident 36's sensory perception was slightly limited; the resident was occasionally moist; chairfast with ability to walk severely limited or non-existent; mobility was slightly limited; nutrition was probably inadequate; and there could be potential problem with friction and shear. A Nursing Assessment- Skilled Form, dated 12/22/2023 at 2:16 A.M., indicated the resident had no hemiplegia, the lower extremities did not have pressure relieving boots, and the resident did not decline lower extremity pressure injury preventative care. Currently has wound/incision receiving treatment but not infected: 1. Pressure related, Non pressure related, incision and none of the above. None of the above was checked. A Nursing "New Skin Alteration" Assessment (non occurrence), dated 12/22/2023 at 1:50 P.M., indicated a new wound, skin alteration - left buttocks near coccyx. 4.5 x 3.0 cm (centimeter) bruise that is sheared in the middle, skin unrolls back over area, DTI (deep tissue injury) to right the heel. A Nursing Assessment - Skilled form, dated 12/24/2023 9:42 P.M., indicated Resident 36 had a wound -pressure related. DTI to sacrum. Resident is turned/repositioned per plan of care. A Nursing Assessment- Skilled form, dated 12/25/2023 at 8:57 P.M., indicated Resident 36 had no wound- pressure area, non pressure area or incision. A Wound Pressure Injury Assessment, dated 12/26/2023 at 1:36 P.M., indicated Resident 36 had a deep tissue pressure injury to the sacrum, originally noted on 12/22/2023, measuring 6 cm x 4		determine if a change in plan is warranted and determine frequency and duration of audits once above frequency is completed.	

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	cm <.1 cm (centimeters). Deep purple, moist and open. Sanguineous (bloody) drainage. MD notified. Current treatment was to cleanse with normal saline and apply hydrocolloid (Non adherent) dressing, and change weekly and as needed. A Nursing Braden Scale (Assessment for Pressure Risk), dated 12/26/2023 at 1:36 P.M., indicated Resident 36's sensory perception was slightly limited; very moist; chairfast ability to walk severely limited or non existent; mobility was very limited; nutrition was probably inadequate; and potential problem with friction and shear. A Wound Pressure Injury Assessment, dated 1/2/2024 at 2:26 P.M., indicated the in house developed pressure wound to sacrum, measured 7.5 cm x 7.0 cm. The wound bed was red, moist with scattered yellow and black moist eschar (dead tissue) covering 75% of the wound bed. Moderated Sanguineous drainage. MD notified. Treatment was cleanse area with normal saline and apply bordered foam dressing. Change every 3 days and as needed A Wound Pressure Injury Assessment, dated 1/10/2024 at 6:44 A.M., indicated Resident 36 had an in house developed pressure injury to the sacrum (DTI - deep tissue injury) now open into unstageable wound. Measured 8 cm x 7 cm x 0. Wound bed was red, moist with yellow/tan slough firmly adhered to the wound bed. Had moderate serosanguinous drainage. Necrosis (dead tissue). MD notified. Current treatment of cleanse with normal saline, apply calcium alginate with silver and cover with bordered dressing, change every 3 days and as needed. Wound Pressure Assessments for the right heel			

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	indicated the following: 12/27---in house DTI RIGHT HEEL -2 cm X 3.5 cm 1/2--- Right heel in house DTI 8 cm x 5 cm 1/3--- MD notification 1/10---Right heel-in house DTI- 8 cm x 6 cm 1/10-MD notification The shower documentation for Resident 36 indicated from admission 12/12/2023 to current 1/11/2024-- the resident had a shower on 12/28/2023, 1/7/2024 and on 1/10/2024 with no mention and or documentation of pressure areas. A current Care Plan, dated 12/26/2023, indicated the resident had developed an pressure injury. Location: sacrum and right heel related to exposure of skin to urinary and fecal incontinence, impaired/decrease mobility and decrease functional ability, refusal of some aspects of care and treatment, under nutrition, malnutrition and hydration deficits. Interventions included, but were not limited to: Assist to turn and reposition approximately every 2 hours while in bed, float heels off bed, lay down between meals to offload sacrum, low air loss mattress settings based on weight. During an observation on 1/11/24 at 10:20 A.M., RN 16 indicated the area to his sacrum was currently unstageable. The resident was lying on an air mattress with a bottom sheet and 2 bed pads. On 1/12/24 at 9:01 A.M., during an interview with Resident 36, he indicated during the hours of 10-6 A.M., the staff usually would turn and reposition him every 3 hours. From 6 A.M. to 2 P.M., they usually didn't turn him and from 2 P.M., to 10 P.M., it was usually one time.			

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	During an interview on 1/12/2024 at 10:30 A.M., QMA 2 indicated they try to encourage the resident to get up, he would get up for therapy. He was supposed to be checked & changed every 2 hours, he was continuously wet. He wets a little at a time with smears of stool when doing checks. They (management) are now looking into getting him side rails to assist turning. On 1/12/2024 at 10:30 A.M., the Assistant Director of Nursing provided the Operational Manual for the air mattress Protect Aire 3000/3500/3600. Installation Instructions... You may place a thin cotton sheet over the quilted mattress top cover...Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the patient. On 1/12/2024 at 10:34 A.M., the Assistant Director of Nursing provided the policy titled, "Skin Management Plan", dated 8/14/2014, and indicated the policy was the one currently used by the facility. The policy indicated"...F. Support Surfaces/Pressure reducing or relieving: ... II. Ensure the surface is being used according to manufacture's instructions...." On 1/12/2024 at 10:35 A.M., the ADON provided the policy titled, "Specialty Mattress Use", dated 4/2/2013, and indicated the policy was the one currently used by the facility. The policy indicated"...VII. Use of a flat sheet to prevent hammocking of mattress, and minimal use of linen layers should be used to ensure therapeutic effectiveness of mattress. Refer to manufacture's guidelines for specific indications regarding linen and incontinence pad use...." During an interview, on 1/12/2024 at 10:55 A.M.,			

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	the Assistant Director of Nursing indicated the resident should have been on 1 sheet per the manufacturer's guidelines. 3.1-40			
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 that an oxygen humidification bottles were changed weekly for 1 of 2 residents reviewed for oxygen use. (Resident 2) Finding includes: During an observation, on 1/9/2024 at 1:59 P.M., Resident 2's humidification bottle was dated 12/25/2023 and 12/31/2023. A record review was completed on 1/9/2024 at 2:12 P.M. Resident 2's diagnoses included, but were not limited to: Morbid obesity, nocturnal hypoxia, cerebrovascular disease and unspecified intracranial injury. A Physician's Order, dated 7/21/2021, indicated to change the oxygen tubing, humidifier, and clean concentrator filter weekly every night shift on	F 0695	It is the policy of Miller's Merry Manor to meet residents respiratory needs according to professional standards of practice. All residents with specialized respiratory needs are at risk for this deficient practice. All residents were checked on 1/25/2024 and have all equipment stored in bags and humidification kits dated. Nurses were re-educated on the policy to change respiratory equipment (cannula's, masks, humidification bottles) weekly and storage when not in use on 1/25/24 and 2/1/24. (Attachment D)	02/02/2024

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	Sundays. A Physician's Order, dated 7/11/2021, indicated Resident 2 was to wear oxygen at 2 liters per nasal cannula on at night. During an observation on 1/10/2024 at 7:28 A.M., Resident 2's humidification bottle was dated 12/25/2023 and 12/31/2023. During an observation on 1/11/2024 at 9:58 A.M., Resident 2's humidification bottle was dated 12/25/2023 and 12/31/2023 with no oxygen tubing storage bag present. During an interview on 1/11/2024 at 10:03 A.M., RN 3 indicated that there were two dates written on the humidification bottle, 12/25/2023 and 12/31/2023, and there should be an oxygen tubing storage bag present. RN 3 indicated all oxygen tubing, humidification bottles and oxygen storage bags are to be changed by the night nurse on Sunday nights. A policy was requested on 1/12/2024 at 10:14 A.M. The MDS (Minimum Data Set Coordinator indicated the facility does not have a specific policy stating when the humidification bottle should be changed, only when the oxygen tubing should be changed, and the bottle was usually changed with the tubing weekly. 3.1-47(a)(6)		To ensure continued compliance, the audit tool "Quality of Care Survey Audit #2" (Attachment B) will be completed daily times 5 days, weekly times 2 weeks and monthly times 2 months. All findings will be reviewed in the monthly QAPI meeting to determine if a change in plan is warranted and determine frequency and duration of the audits once above frequency is completed.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated			

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	with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic			

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	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to limit use of an as needed anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Residents 3) Finding includes: During an interview with Resident 3's representative, she indicated Resident 3 had been on hospice for approximately a month's time. A record review was completed on 1/10/2023 at 11:42 A.M. Diagnoses included, but were not limited to: unspecified dementia, psychotic disorder with delusions, anxiety disorder, and depressive disorder. A Physician's Order, dated 10/28/2023, indicated Resident 3 was to receive lorazepam oral concentrate 2 milligrams per milliliter (mg/ml), 0.25 ml every two hours as needed for anxiety and restlessness. The lorazepam order was discontinued on 11/27/2023. Resident 3 received the as needed lorazepam per the Medication Administration Record on 11/16/2023 at 11:18 A.M., 11/17/2023 at 12:24 P.M., 11/20/2023 at 8:11 A.M., 12:52 P.M., and 3:30 P.M., 11/21/2023 at 6:15 P.M., 11/22/2023 at 10:39 A.M., 11/23/2023 at 9:04 A.M., and 11/25/2023 at 5:41 P.M. A Physician's Progress Note, dated 11/10/2023, indicated Resident 3 was seen and examined. The note indicated to continue with the current medications, but did not address the continued	F 0758	It is the policy of Miller's Merry Manor to not use psychotropic medications on an as needed basis for more than 14 days, unless the prescriber documents why the medication should be extended. All residents prescribed an as needed psychotropic medication are at risk for this deficient practice. Resident #3's psychotropic medication was discontinued 11/27/23. Presently there are no residents on a PRN psychoactive medication. Nurses were educated on psychotropic medications having a 14 day stop date.(Attachment D) To ensure continued compliance, all new orders will be reviewed daily in the clinical meeting to ensure PRN psychotropic medications have a 14 days stop date on an ongoing basis. All psychotropic medications/residents are reviewed monthly in the "Psychotropic/Behavior meeting	02/02/2024

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	use of lorazepam. A Nurse's Note dated, 11/16/2023 at 11:18 A.M., indicated Resident 3 received the as needed lorazepam for appearing anxious and repeatedly asking people to take her to places while down in the dining room. On 11/20/2023 at 12:52 P.M., a Nurse's Note indicated Resident 3 received as needed lorazepam for repeated phrases of, "Do you need me?", "Are you Ready?", "Where are we going?", and "Is that for me?" while reaching out her hands to staff. On 11/20/2023 at 3:30 P.M., a Nurse's Note indicated Resident 3 continued to be restless, and making statements of wanting to throw herself away. On 11/21/2023 at 12:31 P.M., a Nurse's Note indicated Resident 3 had anxiety. On 11/23/2023 at 9:04 P.M., a Nurse's Note indicated Resident 3 continued to grab at staff and repeated herself. She continued to repeat, "Just take me.", while reaching out to staff. During an interview on 1/11/2024 at 1:33 P.M., the Social Service Director (SSD) indicated that as needed psychotropic medications should only be ordered for 14 days, and the initial order should have a stop date for use. If the as needed psychotropic medication needed to be continued, a doctor's note was needed. She indicated the hospice company ordered the medication incorrectly without a stop date. A policy was provided by the Director of Nursing (DON) on 1/12/2024 at 8:45 A.M. The policy titled,		with Psych NP, Consultant Pharmacist and one IDT member.	

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	"Psychotropic Medication Use", indicated, " ...PRN [as needed] Psychotropic medications: PRN orders will be limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days. He/she should document their rationale in the resident's medical record and indicate the duration of the PRN order ...." 3.1-48(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an 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,			

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	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 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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow general Infection Control Practices during incontinence care and a pressure ulcer treatment for 1 of 1 residents reviewed for pressure ulcers. (Resident 36) Findings include: 1. On 1/11/2024 at 10:10 A.M., CNA 4 was observed providing incontinence care to Resident 36. CNA 4 applied gloves, a gown and entered the resident's room. She used the bed controls and raised the bed. CNA 4 removed Residents' soaked brief and placed it in a trash can by the bed. She then removed the top bed pad and put it on the floor, next to the trash can. The aide completed the peri care. After completing the peri care, and without changing her dirty gloves, she applied a new brief to the resident and a new bed pad to the bed. With her gloved hands, CNA 4 rearranged the bed linens, then removed her dirty gloves and picked up a breakfast tray from the over the bed table and exited the room. During an interview, on 1/11/2024 at 10:20 A.M., CNA 4 indicated she should have removed her gloves, washed her hands and applied new gloves. 2. On 1/11/2024 at 10:20 A.M., RN 3, was observed to completed the treatment to Resident 36's pressure ulcer to his sacrum. RN 3 applied her gloves and gown and assisted the resident to turn to the left side. RN 3 applied wiped the residents peri rectal area due to loose stool. She removed	F 0880	It is the policy of Miller's Merry Manor to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections. All residents are at risk for this deficient practice. Resident #36 has been discharged, return not anticipated. CNA4 and RN3 were both verbally counseled and given education on proper handwashing techniques. Nursing assistants were re-educated on hand hygiene on 1/30/2024. (Attachment E) Nurses were re-educated on hand hygiene on 1/25/2024 and 2/01/2024. (Attachment D) To ensure compliance, the "Hand Hygiene Checklist" (Attachment C) provided by State QIO will be used randomly with various tasks by nurse managers. Audits will be completed weekly for 12 weeks to include: 4 observations of PPE use and hand hygiene 4 observations of wound care 4 observations of glucometer use	02/02/2024

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	the urine/feces soaked dressing to the coccyx. The area was black with irregular edges and approximately a 1" ring of redness around the entire wound. RN 3 pulled the residents brief towards her to remove it. She removed her gloves and used hand gel on her hands. RN 3 applied gloves, sprayed the area with normal saline, and wiped the area with a gauze pad With the same gloved hands, she removed a piece of Calcium Alginate and placed it on the mepilex dressing, then placed the dressing on the wound. With the same gloved hands she tried to remove the top bed pad. RN 3 removed her gloves, assisted the resident in bed and rearranged the bed linens. During an interview, on 1/11/2024 at 10:30 A.M., RN 3 indicated she should have removed her gloves and washed her hands after cleaning the wound. On 1/12/2024 at 10:35 A.M., the Assistant Director of Nursing provided the policy titled,"Use of Medical Gloves (application and removal), dated 6/9/2010, and indicated the policy was the one currently used by the facility. The policy indicate"... 3. Guidelines: A. Hands should be washed initially prior to putting on the gloves... D. Gloves should be removed and hands washed with soap and water immediately after glove removal. E. Gloves should be removed and hands washed between care activities with patients...." On 1/12/2024 at 10:36 A.M., the Assistant Director of Nursing provided the policy titled,"Hand Washing and Hand Asepsis", dated 10/27/2016, and indicated the policy was the one currently used by the facility. The policy indicated,"...3. Key procedural points: A. Specific Times Hands Must Be Washed: ... III. Before and after direct resident care...		4 observations of medication administration Any issues observed will immediately be addressed with 1:1 education. Findings will be reviewed in the Monthly QAPI meeting. Monthly audits will continue ongoing.	

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	3.1-18(b)			