STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155557	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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	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: June 11, 12, 13, and 14, 2024 Facility number: 000500 Provider number: 155557 AIM number: 100266220 Census Bed Type: SNF/NF: 53 SNF: 4 Total: 57 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 13 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 21, 2024.	F 0000	Please find the enclosed Plan of Correction as remedies to the alleged deficiencies found during our annual recertification survey conducted from 6/11/24-6/14/24. All areas of concern have been corrected and effective systems and auditing tools are in place to prevent reoccurrence.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to timely complete a Significant Change of Status MDS (Minimum Data Set) Assessment for a resident receiving hospice services and to ensure a Minimum Data Set	F 0641	**F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/20/2024

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

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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	(MDS) Assessment was accurately completed for dental issues for 1 of 1 resident reviewed for Resident Assessment (Resident 45) and 1 of 1 resident reviewed for dental (Resident 16). Findings include: 1. The clinical record for Resident 45 was reviewed on 6/13/24 at 10:00 a.m. The Resident's diagnoses included, but were not limited to, lung cancer and failure to thrive. He was admitted to the facility on 3/25/24. A physician's order, dated 4/17/24, indicated that Resident 45 was admitted to hospice services. The clinical record did not contain a Significant Change of Status MDS that had been completed within 14 days of the hospice admission. During an interview on 6/13/24 at 11:44 a.m., the MDSC (Minimum Data Set Coordinator) indicated that a Significant Change of Status MDS should have been completed when Resident 45 began receiving hospice care. The facility used the RAI (Resident Assessment Instrument) Manual as the policy for completing the MDS. 2. The clinical record for Resident 16 was reviewed on 6/11/23 at 1:40 p.m. Resident 16's diagnosis included, but was not limited to, chronic obstructive pulmonary disorder. The MDS assessments dated 12/5/23 and 6/6/24 indicated Resident 16 was not edentulous. An observation was made of Resident 16 on 6/11/24 at 1:48 p.m. The resident was observed in bed. The resident was observed with no teeth. The resident indicated he had been edentulous for over 10 years.		**practice?** ·Resident 45 A significant Change MDS, A0310A4 (SCSA) was completed on 6/11/2024 to reflect Hospice benefits that was initiated. ·Resident 16 Modification A0050 of significant change A0310A4 dated 6/6/2024 was completed to reflect L0200 B as resident beingedentulous. ·Resident 16 Significant correction to prior Comprehensive A031005 dated 6/19/2024 was completed to reflect L0200B as resident being edentulous ·Resident 16 Careplan was updated to reflect resident's edentulous status **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 ·All residents that are currently receiving Hospice Benefits, reviewed on 6/18/24 to reflect that a Significant Change MDS, A0310A4 was completed upon initiation of Hospice Benefit ·All resident's current dental status was assessed on 6/18/24. Section L0200B was reviewed to reflect correct dental status, Modification A0050 was	

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	A dental visit for Resident 16 was provided by the Social Services Director on 6/13/24 at 10:57 a.m. It indicated the resident was edentulous and "not a good candidate for dentures." An interview was conducted with the MDS Coordinator on 6/13/24 at 2:27 p.m. She indicated the resident does not have teeth. She had updated the resident's medical record to reflect the resident does not have teeth. The Long-Term Care Facility Resident Assessment Instrument 3.0 User 's Manual, Version 1.18.11 October 2023 read "... If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA)..."		completed as needed to reflect current dental status. ·All resident's careplan were reviewed on 6/18/24 and updated, as needed to reflect current dental status. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The MDS Director was in serviced on 6/13/2024 per the RAI Manual that CMS requirement to have a SCSA completed every time the Hospice benefit has been elected. ·The MDS Director and Social Service director was in serviced on 6/13/2024 per the RAI Manual Section L Oral/dental status section L0200D EDENTULOUS Having no natural permanent teeth in the mouth. Complete tooth loss. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·MDS Director or designee will complete the "Accuracy of Assessment" audit tool weekly for 4 weeks, every 2 weeks for 4 weeks, then Monthly on an ongoing basis to ensure continued	

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			compliance. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days (Attachment F).	
F 0686 SS=G 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. Based on observation, interview, and record review, the facility failed to ensure staff accurately identified and monitored skin impairment for a cognitively impaired, dependent resident at risk to develop pressure injuries, failed to ensure interventions for effective pressure relief, and to promote healing, were implemented when an area of concern on the resident's skin was reported to a	F 0686	**Miller's Merry Manor respectfully request an Informal Dispute Resolution (IDR) for tag F-686. See attached supporting information.** **F686** **What corrective action(s) will**	06/20/2024

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	nurse, and failed to ensure care and services were provided to prevent the pressure injury from deteriorating for 1 of 2 residents reviewed for skin integrity (Resident 50). This deficient practice resulted in Resident 50 developing a facility-acquired stage three (full thickness tissue loss) pressure injury." Findings include: The clinical record for Resident 50 was reviewed on 6/11/24 at 3:00 p.m. The resident's admitting diagnoses included, but were not limited to, adult failure to thrive, moderated protein-calorie malnutrition, and Alzheimer's disease. He was admitted to the facility on 2/8/24. A Braden Scale Assessment (assessment to predict pressure ulcer risk), completed 2/8/24, indicated he was at high risk for pressure ulcer development due to decreased mobility, having occasional moisture of the skin, and being bed and chair fast. A care plan, initiated 2/8/24, indicated that Resident 50 was at risk for skin breakdown due to urinary and fecal incontinence, impaired mobility, decreased functional ability, and previously healed wounds to the left buttock and palm of hand. The goal was to provide preventative measures in an attempt to avoid skin breakdown. The interventions included, but were not limited to, monitor skin daily during care, initiated 2/8/24, notify physician and family of any change in skin integrity, initiated 2/8/24, and skin assessment at least weekly by nurse, initiated 2/8/24. A Quarterly MDS (Minimum Data Set) Assessment, completed 6/5/24, indicated his cognition was severely impaired, he required		**be accomplished for those residents found to have been affected by the deficient practice?** Resident 50's plan of care was revised on 6/10/2024 with the development of a skin alteration that was noted on this date. LPN # 5 re-educated on skin management program on 6/17/24 **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 ·100% of all resident's skin has been assessed on or before 6/20/24 assessing to ensure services are provided and interventions are in place and appropriate. Any current skin alterations have been assessed to determine they are noted accurately and according to the facility policy and procedure **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All nursing staff will be re-educated on the facility policy and procedure " Skin Management Program on or before 6/20/24 by the DON or designee (Attachment	

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	maximal assistance of staff for toileting, bathing, dressing, turning in bed, and transfers. He was totally incontinent of bowel and bladder. He did not have a pressure ulcer and was at risk of developing pressure ulcers. Weekly skin assessments were completed by LPN (Licensed Practical Nurse) 5 on 5/26/24, 6/2/24, and 6/9/24 which indicated he did not have any new skin breakdown or pressure ulcer. A physician's order, dated 6/10/24, indicated to cleanse wound on right buttock with normal saline, pat dry, apply Medi honey (wound treatment gel) and alginate (wound dressing) into the wound bed, apply skin prep to surrounding area and cover with a bordered foam dressing daily and as needed for soiling or dislodgement. A Pressure Injury Assessment, dated 6/11/24, indicated the pressure injury was originally noted on 6/10/24 and located on lower right buttock and was a stage 3 that was new and acquired in-house. The wound bed exhibited 1-25% necrosis (dead tissue). Ecchymosis (bruised/ discolored) surrounding wound. There was light drainage and no odor. The physician and family were notified of the pressure injury. On 6/14/24 at 2:04 p.m., Resident 50's right buttock wound was observed with the DON (Director of Nursing) and the WN (Wound Nurse). Resident 50 was resting on a low air loss mattress. The dressing was removed, and the wound was approximately the size of a silver dollar. The wound bed had necrotic tissue which was light brown and soft in appearance. There was a thin line of pink colored tissue surrounding the wound bed and the skin surrounding the wound was flesh tone. The WN completed the dressing as		D) ·Flashlights will be provided on each med cart to ensure additional lighting is in place on or before 6/20/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON or other designee will be responsible to complete the QA tool " Pressure Ulcer Risk and Treatment" will be used to monitor for compliance. Tool will be completed 5x a week for 4 weeks, then 3x a week for 2 weeks, then monthly on an ongoing basis to ensure continued compliance. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days (Attachment E)	

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	ordered by the physician. During an interview on 6/14/24 at 2:04 p.m., the DON and the WN indicated there was necrotic tissue present in the wound bed of the pressure ulcer on the right buttock. The DON and WN had been informed of the pressure ulcer when it was about this size. They were unsure as to why it was not found or reported earlier. The staff could have assumed it was the moisture associated skin damage which had been treated on the left hip and healed in May 2024 and thought they knew about the area. During an interview on 6/14/24 at 2:15 p.m., CNA (Certified Nursing Assistant) 3 indicated she had cared for Resident 50 about a week ago and had noticed an area on his right buttock. CNA 3 had informed LPN (Licensed Practical Nurse) 4. During an interview on 6/14/24 at 2:20 p.m., LPN 4 indicated she had not been told about any skin concerns until the WN informed after the WN had found the wound on the right buttock. LPN 4 was not aware of any skin issues prior to being told by the WN. During an interview on 6/14/24 at 2:53 p.m., LPN 5 indicated she had completed the weekly skin assessment during the night shift on 6/9/24. She had not seen any new skin areas. There was one skin area that was being treated on his left buttock. She did not recall a skin area on Resident 50's right buttock. She did not always turn the lights on all the way, which could have affected it. LPN 5 had not been informed of any new skin areas by the nursing staff during her shift. During an interview on 6/14/24 at 03:47 p.m., the DON indicated that a low air loss mattress had			

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	been obtained for Resident 50 the day the pressure ulcer on his right buttock was found. Resident 50 was receiving barrier cream to the area prior to the pressure ulcer being found. On 6/14/24 at 3:20 p.m., the Executive Director provided the Skin Management Program policy, dated 8/14/2014, which read "...It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin alterations unless the individual's condition demonstrates that the development is clinically unavoidable...A comprehensive head to toe skin assessment [inspection] will be completed by a licensed nurse upon admission/ return, and at least weekly thereafter... Residents who received assistance with bathing and/or peri-care will be observed daily by nursing staff and any notation of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment... Notification/ communication will occur with the resident/ sponsor and physician when there is a change in condition and /or change in treatment plan...Nursing staff will communicate changes via the 24 hour condition report... DON or designee will be alerted to all new skin alterations via the EMR [sic] dashboard and the 24 hr. report and will oversee that all assessment and documentation is completed...." 3.1-40(a)(1) 3.1-40(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			

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

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to use gloves and perform hand hygiene when providing care to a resident whose leg was bleeding in the common area of the unit for 1 of 1 resident randomly observed. (Resident 40) Findings include: The clinical record for Resident 40 was reviewed on 6/11/24 at 1:40 p.m. Her diagnosis included, but were not limited to, Alzheimer's disease. She	F 0880	**F880 Hand Hygiene and use of medical gloves** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** CNA #1 was re-educated on the facility policy and procedure "Hand Washing and Hand Asepsis" and " Use of Medical Gloves" on 6/12/24 by the DON or designee and voiced	06/20/2024

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	resided on the memory care unit of the facility. An observation of Resident 40 and interview with CNA (Certified Nursing Assistant) 1 was conducted on 6/11/24 at 1:41 p.m. Resident 40 was sitting down on the couch in the television area located in the middle of the unit. Resident 40 pulled her right pant leg up to her knee and began scratching her leg. There was blood dripping down Resident 40's right leg near the inner side of her calf area. CNA (Certified Nursing Assistant) 1 was sitting at the nurse's desk and informed of the blood on Resident 40's right leg. CNA 1 indicated she would inform the nurse. CNA 1 got up from the nurse's desk, came over to Resident 40 at the couch, and bent down with tissue paper and a pair of gloves in her hands. CNA 1 used the tissue paper with her bare right hand to wipe the blood from Resident 40's right leg and did not put on the gloves she had in her left hand. After wiping, she folded the tissue paper in half, walked down the hall to the unit exit doors, punched the code into the keypad to exit the unit, and exited the unit. CNA 1 did not wash her hands after she wiped the blood from Resident 40's leg and prior to exiting the unit. An interview was conducted with the DON (Director of Nursing) on 6/11/24 at 3:45 p.m. She indicated after speaking with staff about the above observation, she thought there was an infection control issue regarding glove use and hand hygiene. The Hand Washing and Hand Asepsis policy was provided by the ED (Executive Director) on 6/12/24 at 11:40 a.m. It read, "To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a		understanding(Attachments A & B) **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 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All nursing staff will be re-educated on the facility policy and procedure “Hand Washing and Hand Asepsis” and “ Use of Medical Gloves” on or before 6/20/24 by the DON or designee (Attachments A & B) ·100% staff education completed to all nursing staff on or before 6/20/24 by DON or designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON or other designee will be responsible to complete the QA tool “**Infection Control Review- Hand Hygiene/ Glove use**” will be used to monitor for compliance. Tool will be	

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MILLER'S MERRY MANOR	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clean environment and assist in the prevention of and the transmission of disease and infection. This facility follows the recommendations for handwash and hand hygiene recommended by the CDC (Centers for Disease Control....) SPECIFIC TIMES HANDS MUST BE WASHED: ...Before and after direct resident contact." The Use of Medical Gloves policy was provided by the ED on 6/12/24 at 3:50 a.m. It read, "Medical glove use by HCW's [health care workers] is recommended for two main reasons: 1) to reduce the risk of contaminating the HCW's hands with blood and other body fluids, 2) to reduce the risk of the germ dissemination to the environment and the transmission from the HCW's to the patient and vice versa, as well as from one patient to another. Gloves are worn to provide a protective barrier and prevent gross [sic] contamination of the hands when touching blood, body fluids, specimen collection, secretions, excretions, mucus [sic] membranes and non-intact skin...Gloves should be removed and hands washed with soap and water immediately after glove removal. (Hand washing with soap and water is highly recommended when gloves are removed because of a tear or puncture and the HCW has had contact with blood or another body fluid, hand rub with alcohol gel may be used only if soap and water is not available upon removal of gloves.)" 3.1-18(b)(1) 3.1-18(l)		completed 5x a week for 4 weeks, then 3x a week for 2 weeks, then monthly on an ongoing basis to ensure continued compliance. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days (Attachment C)	