STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155299	A. BUILDING 00 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 5, 6, 7, and 8, 2022 Facility number: 000196 Provider number: 155299 AIM number: 100267390 Census Bed Type: SNF/NF: 34 SNF: 3 Total: 37 Census Payor Type: Medicare: 8 Medicaid: 17 Other: 12 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/12/22.	F 0000	This Plan of Correction shall serve as this facility's Credible Allegation of Compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve quality of care and comply with all applicable state and federal regulatory requirements. Please consider permitting submission of audit and education as evidence of compliance with the state and federal requirements identified in the survey. Respectfully Submitted, Beth Ingram Executive Director	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Ingram	Executive Director	12/21/2022

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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	Based on observation, record review, and interview, the facility failed to assess and treat areas of cellulitis (bacterial skin infection) to a resident's legs for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 187) Finding includes: During an interview with Resident 187 on 12/5/22 at 10:19 a.m., the resident indicated he had a skin condition to both lower legs but could not explain what it was. There was gauze observed underneath his non-skid socks on both legs. On 12/6/22 at 2:24 p.m., RN 1 removed the resident's non-skid socks and there were gauze dressings noted to both lower extremities. She removed the gauze dressing and there were xeroform treatments observed underneath on both lower extremities. There were no dates on either dressing. Both lower extremities were red in color and there were scattered scabbed areas. The surrounding skin was very dry and flaky. RN 1 indicated there were no orders for wound dressings to either lower extremity and she was not aware that he had dressings to either lower extremity. Resident 187's record was reviewed on 12/6/22 at 9:22 a.m. The resident was admitted to the facility on 12/1/22. Diagnoses included, but were not limited to, cellulitis of the right lower limb, renal insufficiency, high blood pressure, and acute embolism and thrombosis (blood clot) of the deep veins in the right lower extremity. A Nurse Practitioner Note, dated 12/2/22 at 1:40 p.m., indicated the resident was admitted to the facility for skilled nursing and rehabilitation. On	F 0684	Step One:The area was assessed on 12/6/22 and found to have no open areas. The physician was notified and the order updated. Step Two: Residents with non pressure related skin conditions were checked for assessed and none were found lacking assessment. Step Three: Nursing staff were re-educated to the importance of routine assessment of non pressure related skin conditions. Step Four: The Director of Nursing or her designee will audit assessments of non pressure related skin conditions. Up to 10 Assessments will be audited weekly during weeks 1-4, then up to 8 assessments weekly during weeks 5-8, then 6 assessments weekly during weeks 9-13, then 4 assessments during weeks 14-18, then 2 assessments weekly during weeks 19-24. Results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audit.	12/23/2022

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	11/22/22 in the emergency department, he was noted to have bilateral lower extremity wounds. He was diagnosed with chronic venous stasis dermatitis with cellulitis. The plan included, but was not limited to, supportive care to the chronic venous stasis dermatitis with cellulitis and continue to monitor. Daily nursing assessments from 12/1/22 - 12/4/22, indicated the resident was receiving an antibiotic treatment for right leg cellulitis. The right leg gauze dressing was clean and dry. There was no documentation of a complete skin/wound assessment of either lower extremity or dressing changes completed. The record lacked an order for a treatment or dressing to the right and left lower extremities. Interview with the Director of Nursing on 12/6/22 at 3:05 p.m., indicated there was no order for the xeroform dressing with gauze treatment. The nurse that had admitted the resident indicated she had removed the original dressings on the date of admission and just replaced the dressing at that time. There was no further documentation related to dressing changes that occurred. 3.1-37(a)			
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			

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	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 monitor the resident's level of pain prior to the administration of a pain medication for 2 of 5 residents reviewed for unnecessary medications. (Residents 27 and 137) Findings include: 1. The record for Resident 27 was reviewed on 12/6/22 at 2:20 p.m. The resident was admitted on 9/27/22. Diagnoses included, but were not limited to, displaced fracture of upper end of right humerus, history of falling, vascular dementia, fracture of one rib left side, anxiety disorder, and depression. The Admission Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was cognitively intact. She was an extensive assist with a 2 person plus staff assist for bed mobility and transfers. The resident had a history of falls prior to admission and sustained a fracture as a result of a fall.	F 0757	Step One: Pain medication orders for both residents were updated to include pain assessment. Step Two: All routine pain orders were audited and updated to include assessment of pain as needed. Step Three: Nursing staff were re-educated to the importance of pain prior to administration of a pain medication. Step Four: The Director of Nursing or her designee will audit pain assessments. Up to 10 pain Assessments will be audited weekly during weeks 1-4, then up to 8 assessments weekly during weeks 5-8, then 6 assessments weekly during weeks 9-13, then 4 assessments during weeks 14-18,	12/23/2022

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	A Care Plan, dated 9/28/22, indicated the resident had the potential for pain/discomfort related to a fracture of the right humerus and/or generalized pain/discomfort. The approaches were to assess pain using the 0-10 scale. A Care Plan, dated 10/1/22, indicated the resident had cognitive impairments related to vascular dementia. Physician's Orders, dated 9/29/22, indicated Acetaminophen 650 milligrams (mg) two times a day for pain. The times to be administered was every a.m.(morning) and hs (night). A pain assessment was primarily completed on the midnight shift for the months of 10/2022, 11/2022, and 12/2022. There was no pain assessment completed prior to the administration of the Acetaminophen. Interview with the Director of Nursing on 12/7/22 at 11:30 a.m., indicated there was no pain assessment documented prior to the administration of the Acetaminophen. 2. The record for Resident 137 was reviewed on 12/6/22 at 10:30 a.m. The resident was admitted on 11/15/22. Diagnoses included, but were not limited to, fracture of right femur, perforation of intestine, major depressive disorder, anxiety disorder, and osteoarthritis. The Admission Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident was cognitively intact. In the last 7 days, the resident had received an opioid medication 7 times.		then 2 assessments weekly during weeks 19-24. Results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audit.	

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	A Care Plan, dated 11/15/22, indicated the resident had the potential for pain/discomfort related to a right hip fracture and osteoarthritis. The approaches were to assess pain using the 0-10 scale. Physician's Orders, dated 11/22/22, indicated Hydrocodone-Acetaminophen Tablet (a narcotic pain medication) 5-325 milligrams (mg), give 1 tablet by mouth every 4 hours for hip fracture pain. The administration times were 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Physician's Orders, dated 12/3/22, indicated Hydrocodone-Acetaminophen Tablet 5-325 mg, give 1 tablet by mouth every 6 hours for pain. The administration times were 12:00 a.m., 6:15 a.m., 12:00 p.m., and 6:15 p.m. There were no pain assessments completed prior to the administration of the pain medication on 11/23, 11/25, 11/26, 11/27, 11/29, 12/1, and 12/6/22 for all of the scheduled administration times. There were pain assessments completed only on the following days and times and not with the other scheduled daily medication administrations: 11/24/22 at 10:36 a.m. 11/28/22 at 1:34 p.m. 11/30/22 at 9:41 a.m. 12/2/22 at 11:19 a.m. 12/3/22 at 10:06 a.m. and 4:59 p.m. 12/4/22 at 9:49 a.m., and 3:35 p.m. 12/5/22 at 12:54 p.m., 1:03 p.m., and 6:43 p.m. Interview with LPN 1 on 12/6/22 at 1:00 p.m., indicated she asked the resident what her pain level was prior to administration of the of the Hydrocodone. She indicated there was a place in			

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	the computer to document the resident's level of pain. Interview with the Director of Nursing on 12/7/22 at 10:30 a.m., indicated the pain assessment was to "pop up" before the administration of the medication. She returned at 11:00 a.m. and indicated there was a glitch in the system and the pain assessment was not put into the order, therefore there was no documentation of the resident's pain level prior to the administration of the Hydrocodone. 3.1-48(a)(3)			