| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155557 | A. BUILDING 00<br>B. WING | 05/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| MILLER'S MERRY MANOR | 1651 N CAMPBELL ST<br>INDIANAPOLIS, IN 46218 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: May 15, 16, 17, 18, and 19, 2023<br><br>Facility number: 000500<br>Provider number: 155557<br>AIM number: 100266220<br><br>Census Bed Type:<br>SNF/NF: 54<br>SNF: 3<br>Total: 57<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 46<br>Other: 9<br>Total: 57<br><br>These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 24, 2023 | F 0000 | Please find the enclosed Plan of Correction as remedies to the deficiencies found during our annual recertification survey ending on May 19, 2023. We respectfully request consideration for Paper Compliance in lieu of revisit. All areas have been corrected and effective systems and auditing tools are in place to prevent reoccurrence. | |
| F 0585<br>SS=D<br>Bldg. 00 | 483.10(j)(1)-(4)<br>Grievances<br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Jance Peterson | Administrator | 06/04/2023 |

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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| | and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance | | | |

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| | process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey | | | |

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| | Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>Based on interview and record review, the facility failed to take prompt efforts to resolve an oral grievance from a resident regarding missing clothing items for 1 of 1 residents reviewed for personal property. (Resident 6)<br><br>Finding include:<br><br>The clinical record for Resident 6 was reviewed on 5/17/23 at 4:29 p.m. Resident 6's diagnoses included, but not limited to, diabetes type II, hypertension, non-pressure chronic ulcer of the left foot, cardiomegaly (enlarged heart), and chronic kidney disease.<br><br>The quarterly MDS (Minimum Data Set) dated 3/31/23 indicated, Resident 6 was cognitively intact and could make daily healthcare decisions for himself.<br><br>An admission MDS dated 12/30/22 indicated, his preferences for how important it was for him to: choose what clothes to wear, to take care of his personal belongings or things; and importance of having a place to lock his things up to keep them safe was "very important"<br><br>Resident 6's care plan dated 12/30/22 indicated, He had expressed during the assessment process that it was important to him to take care of his personal belongings. Some interventions were to discuss with the resident regarding placement of items in | F 0585 | F585 Grievances<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Grievance form has been completed and resolved for the resident found to be affected by the deficient practice.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents residing in the facility with a grievance had the potential to be affected by this alleged deficient practice.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· Re-education with all staff on “Grievance Procedure” will be completed on or before 6/5/2023 to ensure the alleged deficient practice does not recur. (Attachment A)<br>**How the corrective action(s) will be monitored to ensure the** | 06/05/2023 |

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| | room, assistance with securing items as needed, and to ensure family/friend was invited to care plan meetings.<br><br>An interview with Resident 6 was conducted on 5/16/23 at 9:23 a.m. Resident 6 indicated, a week ago his dobb kit (containing his soap, shower wash and shampoo) went missing from the top of his bedside night stand along with a can of orange soda. Additionally, he indicated about three months ago, when he had moved from one room to his present room, his clothing had gone missing. He stated he was missing 10 pairs of underwear, pants, shirts, and a jogging suit. He stated that now he and his roommate will not leave the room unattended for fear that more of their items would be taken.<br><br>An interview with ED (Executive Director) was conducted on 5/17/23 at 11:53 a.m. ED indicated, the facility did not have any grievance forms from Resident 6 within the last year.<br><br>An interview with Resident 6's family member (FM 7) conducted on 5/17/23 at 2:38 p.m. indicated, her father had been moved from one room to his present room and when they moved him, his clothing did not get moved with him. She stated, he had told his nurse as well as the oncoming shift's nurse of the fact that he was missing his clothing. He was told by the nurses that they must have been left in his closet in his old room and would check to see if they were still there but, when they did check, his clothing was not there. The nurses then told Resident 6 that perhaps laundry had taken them. FM 7 indicated, she was unable to visit her dad for a couple weeks after his room move but when she did visit, she noticed that her dad's outfit was unclean and he was now wearing incontinence briefs. When she asked him | | **deficient practice will not recur, i.e., what quality assurance program will be put into place;**<br>· The QA tool titled, "Grievance Policy Review" will be Completed by the SS Director or designee 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment B) | |

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| | about his appearance, he told her that his clothing was still missing which included all of his underwear so he had to wear the incontinent briefs as underwear. FM 7 stated, on that day, she went and spoke with his nurse who indicated, they would have to look into it. FM 7 indicated, she had received a phone call from the facility regarding his lost clothes. FM 7 indicated, the person who called her identified themselves as the business office manager and told her the facility was unable to locate his clothing and because they were not labeled with his name, that there was nothing they could do about it. FM 7 indicated, the person who called her also asked if she had a receipt for the missing clothing, but FM 7 no longer had the receipt. FM 7 indicated, her dad was missing 2 ten packs of underwear, 2 jogging suits, and some tops and bottoms from Wal-mart. Additionally, she stated that even his orthotic inserts he had for his shoe was missing.<br><br>An interview with Social Services Director (SSD) conducted on 5/17/23 at 3:27 p.m. indicated, she was not made aware of Resident 6 missing clothing items, a can of orange soda, or his dobb kit.<br><br>A Grievance Procedure policy was received on 5/17/23 at 11:35 a.m. from ED. The policy indicated, the facility "strives to address all resident concerns and complaints immediately to the satisfaction of the resident and/ or family. Residents and families are encouraged to speak to any staff whenever their expectations of care and service are not met so immediate action can be taken...Miller's Merry Manor will investigate, act upon and resolve to the best of our ability any resident or family concern/grievance that cannot be immediately resolved...Procedure...Resident may verbally file a grievance with any staff | | | |

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| | member or may request a specific staff member to speak to...Any alleged violations involving neglect, abuse...and/or misappropriation of resident property will be reported immediately to the administrator...Follow up with the involved party will be completed until the concern is resolved to the satisfaction of the resident and/or involved party and documented on the form...Staff will be trained upon hire and throughout employment on how to receive grievance voiced by residents and/or family members."<br><br>3.1-7(a)<br>3.1-7(b) | | | |
| F 0640<br>SS=B<br>Bldg. 00 | 483.20(f)(1)-(4)<br>Encoding/Transmitting Resident Assessments<br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a | | | |

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| | format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br><br>Based on interview and record review, the facility failed to timely complete and transmit discharge tracking forms for 5 of 17 resident reviewed for Minimum Data Set Assessments (Resident 12, 23, 53, 59, and 60).<br><br>Findings include: | F 0640 | F640 Encoding/Transmitting Resident Assessments<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>·Resident #60, has since had a Discharge assessment with an | 06/05/2023 |

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| | 1. Resident 23 was discharged from the facility on 12/19/22. The clinical record did not contain a discharge tracking record that had been transmitted to CMS (Center for Medicare and Services).<br><br>2. Resident 60 was discharged from the facility on 1/19/23. The clinical record did not contain a discharge tracking record that had been transmitted to CMS.<br><br>3. Resident 59 was discharged from the facility on 1/24/23. The clinical record did not contain a discharge tracking record that had been transmitted to CMS.<br><br>4. Resident 12 was discharged from the facility on 1/26/23. The clinical record did not contain a discharge tracking record that had been transmitted to CMS.<br><br>5. Resident 53 was discharged from the facility on 1/26/23. The clinical record did not contain a discharge tracking record that had been transmitted to CMS.<br><br>During an interview on 5/18/23 at 10:53 a.m., the Minimum Data Set Coordinator indicated the discharge tracking forms should have been completed in the clinical record and transmitted to CMS timely. The facility used the Resident Assessment Instrument Manual as the policy for completing MDS Assessments.<br><br>The current Resident Assessment Instrument Manual was retrieved from the CMS website on 5/19/23 and read "...09. Discharge Assessment-Return Not Anticipated... Must be completed when the resident is discharged from the facility and the resident is not expected to | | ARD date of 01/19/2023 and was completed, transmitted, and accepted on 5/17/2023.<br>·Resident #59, has since had a Discharge assessment with an ARD date of 01/24/2023 and was completed, transmitted, and accepted on 5/17/2023.<br>·Resident #12, has since had a Discharge assessment with an ARD date of 01/26/2023 and was completed, transmitted, and accepted on 5/17/2023.<br>·Resident #53, has since had a Discharge assessment with an ARD date of 01/19/2023 and was completed, transmitted, and accepted on 5/17/2023.<br>·Resident #23, had a Discharge assessment with an ARD date of 01/19/2023 and was completed, transmitted, and accepted on 5/17/2023.<br>·Resident #23, had a Discharge assessment with an ARD date of 12/19/2022 and was completed on 12/20/2022, and was transmitted, and accepted on 12/26/2022<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>·All residents residing in the facility have the potential to be affected by the alleged deficient practice<br>·100% audit of all discharges in the last 6 months have been | |

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| | return to the facility within 30 days... Must be complete... within 14 days after the discharge date ...Must be submitted within 14 days after the MDS completion date..." | | reviewed to ensure no other discharge MDS's were incomplete.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· MDS coordinator or designee was re-educated on the RAI MDS 3.0 manual section Non-Comprehensive Assessments and Entry and Discharge Reporting "Timeliness Criteria" on 05/31/2023 (Attachment C)<br><br>**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;**<br>· The DON or other designee will be responsible to complete the QA tool "**Encoding/Transmitting Discharge Resident Assessments**" to monitor for compliance. Tool will be completed weekly 4x weeks, then 2x a month x2months 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 | |

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| | | | Quality Assurance meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days (Attachment D) | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br>Based on observation, interview and record review, the facility failed to ensure a humidifier was provided for a resident using oxygen therapy for 1 of 1 resident reviewed for oxygen. (Resident 21)<br><br>Findings include:<br><br>The clinical record for Resident 21 was reviewed on 5/16/23 at 9:44 a.m. The diagnoses included, but were not limited to, chronic pain, obstructive sleep apena, chronic respiratory failure and Chronic Obstructive Pulmonary Disease (COPD).<br><br>A respiratory care plan for Resident 21 dated 12/8/22 indicated the staff was to administer oxygen, medications and treatments as ordered.<br><br>A physician order dated 12/8/23 indicated "...Check oxygen flow rate: tank level; tube patency; portable/concentrator function; | F 0695 | F 695 Respiratory/Tracheostomy Care and Suctioning<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #21 humidity was changed on 5/17/23 upon discovery of an empty bottle.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents who have oxygen ordered have the potential to be affected by the alleged deficient practice.<br>· All residents who have oxygen ordered will be audited to | 06/05/2023 |

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| | humidifier level every 4 hr."<br><br>A physician order dated 12/11/22 indicated the staff was to change humidifier and clean concentrator filter every Sunday on night shift.<br><br>A physician order dated 12/8/23 indicated Resident 21 was to receive 4 liters of continuous oxygen.<br><br>An observation was made of Resident 21 on 5/16/23 at 9:44 a.m. The resident was observed with a nasal cannula in his nose and oxygen was running through it. Resident 21 indicated at that time, the staff do not always replace the humidifier on the concentrator of the oxygen unit. His nose gets dry. It "feels good" when he does have it. The humidifier bottle was observed empty.<br><br>An observation was made of Resident 21 on 5/17/23 at 11:35 a.m. The resident's oxygen concentrator was observed with an empty humidifier bottle. The resident indicated at that time, the staff had not changed out the humidifier.<br><br>An interview was conducted with License Practical Nurse (LPN) 5 on 5/17/23 at 11:45 a.m. She indicated she was Resident 21's nurse that day. The humidifier was changed every Sunday night. She was unsure why it had not been done.<br><br>3.1-47(6) | | ensure they have humidity applied to their oxygen as well as an order to change humidity weekly and to check humidity every 4 hours.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All nursing staff will be re-educated on the facility policy and procedure “Oxygen and Nasal Canula” on or before 6/5/2023. (Attachment E)<br>**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;**<br>·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director<br>·The QA tool “Nursing Services QA Review” will be utilized 5x week x 4 weeks, 2x week x 4 weeks, monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool | |

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| | | | "Nursing Services QA Review" (ATTACHMENT F) specifically monitoring care plan accuracy and revision. | |
| F 0697 SS=D Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on interview and record review, the facility failed to address a resident's pain utilizing nonpharmacological interventions for 1 of 1 residents reviewed for pain. (Resident 21)<br><br>Findings include:<br><br>The clinical record for Resident 21 was reviewed on 5/16/23 at 9:44 a.m. The diagnoses included, but were not limited to, chronic pain, obstructive sleep apena, chronic respiratory failure and Chronic Obstructive Pulmonary Disease (COPD).<br><br>A pain care plan for Resident 21 dated 12/9/22 indicated the goal was for the resident's pain would be at a tolerable level. The interventions were the following: "...Assess pain using the 0-10 scale [1 being the least amount of pain and 10 being the most amount of pain]. , Instruct resident to take pain medication before pain becomes severe to achieve better pain control,... Administer pain medication as per MD orders and note the effectiveness,..Document/Report complaints & non-verbal signs of pain..."<br><br>A physician order dated 5/11/23 indicated | F 0697 | F697 Pain Management<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #21 continues to reside at the facility. The facility has followed up with his chronic pain with ortho who he was following prior to survey.<br>· Resident #21's orders updated to reflect nonpharmacological interventions to be completed prior to giving oral pain medications.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>·All residents residing in the facility have the potential to be affected by the alleged deficient practice | 06/05/2023 |

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| | Resident 21 was to receive Biofreeze on both knees four times a day for pain.<br><br>A physician order dated 4/14/23 indicated Resident 21 was to receive 325 milligrams of Tylenol for pain management three times a day.<br><br>The May 2023 Medication Administration Record (MAR) indicated the following days and shifts the resident indicated he was in pain, and the pain severity level:<br>5/1/23 = a.m., - pain level of 6, mid day - pain level of 6, night - pain level 3,<br>5/2/23 = a.m., - pain level of 6, mid day - pain level of 7, night - pain level 3,<br>5/3/23 = a.m., - pain level of 6, mid day - pain level of 6, night,<br>5/4/23 = a.m., - pain level of 6, mid day - pain level of 5, night - pain level 2,<br>5/5/23 = a.m., - pain level of 7, mid day - pain level of 6, night - pain level 2,<br>5/7/23 = a.m., - pain level of 2,<br>5/8/23 = a.m., - pain level of 8, mid day - pain level of 6, night - pain level 1,<br>5/9/23 = a.m., - pain level of 7, mid day - pain level of 6,<br>5/10/23 = a.m., - pain level of 8, mid day - pain level of 6, night - pain level 2,<br>5/11/23 = a.m., - pain level of 7, mid day - pain level of 6, night - pain level 1,<br>5/12/23 = night - pain level 2,<br>5/15/23 = a.m., - pain level of 6, mid day - pain level of 8,<br>5/16/23 = a.m., - pain level of 7, mid day - pain level of 8,<br>5/17/23 = a.m., - pain level of 7, mid day - pain level of 6, and<br>5/18/23 = a.m. - pain level of 9<br><br>An interview was conducted with Resident 21 on | | ·All residents' orders were updated to reflect monitoring for nursing to "Monitor for verbal or non-verbal evidence of pain/discomfort. If noted provide appropriate intervention as needed"<br>·All resident's orders were updated to reflect interventions to review prior to PRN pain medications that are nonpharmacological.<br>·Licensed Nursing Staff and QMA's will be in-serviced on the Pain Management Policy and Procedure on documenting nonpharmacological interventions or before 6/5/2023. Pain management administration documentation will be monitored by Director of Nursing/Designee to ensure nonpharmacological interventions are reviewed prior to PRN pain medications given.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>·All Licensed Nursing staff and QMA's will be re-educated on the facility policy and procedure "Pain Management Program Policy and Procedure" on or before 6/5/2023 by the DON or designee (Attachment G) | |

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| | 5/16/23 at 9:41 a.m. He indicated he has pain in his lower extremities. The staff give him Tylenol to address his pain, but it does not relieve his pain. The resident reported at that time, his pain in his lower legs were at a pain severity of a 9.<br><br>The resident's clinical record did not indicate nonpharmacological interventions were provided to address a resident's pain.<br><br>An interview was conducted with License Practical Nurse (LPN) 5 on 5/17/23 at 11:45 a.m. She indicated the resident does complain about his pain in his legs. The resident receives Tylenol and Biofreeze topically for pain management. The resident was not compliant with wearing his CPAP [Continuous Positive Airway Pressure] during the times of sleeping, so the medical provider can not order any additional stronger pain medications due to the concern with affecting the resident's breathing.<br><br>An interview was conducted with the Director of Nursing on 5/17/23 at 3:33 p.m. She indicated the staff should be offering, providing and documenting nonpharmacologiccal interventions to address Resident 21's pain.<br><br>3.1-37(a) | | **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;**<br>· The DON or other designee will be responsible to complete the QA tool "Pain Assessment and Review" will be used to monitor for compliance. Tool will be completed 3x week for 4 weeks, then 2x 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 H) | |
| F 0744<br>SS=D<br>Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on observation, interview, and record review, the facility failed to provide appropriate | F 0744 | *F744 Treatment/Service for Dementia | 06/05/2023 |

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| | dementia care services to 1 of 6 residents reviewed for dementia care. (Resident 24)<br><br>Findings include:<br><br>The clinical record for Resident 24 was reviewed on 5/16/23 at 9:20 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease and dementia.<br><br>The undated memory care functional maintenance plan indicated, "Late state dementia. Cognition is severely impaired. Lack awareness on the effects that actions have on objects or other people. Able to use simple communication. Needs to feel stable. Can perform gross motor movements and is mobile (may be able to sit, stand, walk). Maximum assistance with all activities of daily living to prevent falls and wandering."<br><br>The cognition care plan, last reviewed 4/18/23, indicated interventions were to ensure staff explain procedures at initiation of each interaction with resident and allow time to process and to gently redirect activities when resident makes inappropriate actions.<br><br>An observation of the memory care unit was made on 5/16/23 at 9:24 a.m. Resident 24 was sitting at a table in the dining room. She had an abrasion above her left eye. There was a Christmas tree in the television lounge area of the unit, decorated in red, white, and blue holiday decorations. The decorations were bows, garland, and stars that did not include any hooks or sharp objects.<br><br>The 5/13/23, 4:30 p.m. nursing occurrence initial assessment, written by LPN (Licensed Practical Nurse) 8, indicated Resident 24 had a fall with injury in the hallway by the television lounge. The | | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· LPN #8 was immediately re-educated on 5/16/2023 regarding caring for dementia residents.<br>· Resident #24 continues to reside on the specialty unit appropriately with no noted distress from incident.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents with a dementia diagnosis had the potential to be affected by this alleged deficient practice.<br>· All staff will be re-educated on “Communication Techniques for Alzheimer’s Resident” policy on or 6/5/2023. (Attachment I ).<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All staff will be re-educated on “Communication Techniques for Alzheimer’s Resident” policy on or 6/5/2023. (Attachment I).<br>**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** | |

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| | type of injury sustained was a bruise/hematoma and abrasion. It read, "resident pulled decorations of [sic] the tree in the lounge writer tried to get decorations from resident then resident started to walk in a fast pace went to help resident to slow down when resident was approached the resident jerked away and fell to the floor assisted resident up in chair noticed resident's nose was bleeding from the right nostril applied a gauze had moderate amount of bleeding before it stopped has abrasion above left eye and a red bruise under left eye."<br><br>The 5/15/23 nurse practitioner note read, "Plan: s/p [status post] witnessed fall. Neuro [neurological] check at baseline. Remains ambulatory w/o [without] assistive. Abrasion x [times] 2 above L [left] eye and at corner of L [left] eye. Will add bacitracin. Fall precautions. Encourage safe and supportive environment."<br><br>The 5/15/23 post occurrence IDT (Interdisciplinary Team) & fall risk assessment indicated the root cause was, "as resident was being approached by staff, she jerked away causing her to lose her balance and fall to the floor." The IDT recommendations were, "staff education, if resident has something in her hands to go ahead and allow her to keep it until she puts it down. Don't try and take it away from her, unless it will cause someone or herself harm."<br><br>An interview was conducted with the SSD (Social Services Director) on 5/18/23 at 10:25 a.m. She indicated she was part of the 5/15/23 IDT review of Resident 24's fall. The facility did not currently have a memory care director for the unit. She would have let Resident 24 take the decorations and retrieve them later. | | **into place;**<br>The QA tool titled, “Dementia care competency” will be utilized by the SSD or designee 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment J) | |

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| | An interview was conducted with the DON (Director of Nursing) on 5/18/23 at 10:34 a.m. She indicated she was not present in the facility when Resident 24 fell. Resident 24 was "really upset" about it. It was hard to redirect her. "My fix was let her have the decorations, and we'll redirect her later." It wasn't worth Resident 24 getting upset or causing her any distress.<br><br>An interview was conducted with LPN 8 on 5/18/23 at 10:56 a.m. She indicated she worked the memory care unit of the facility over the weekend and there was an incident with Resident 24. LPN 8 was standing in the common area across from the television lounge when she saw Resident 24 rip a piece of garland off the tree. LPN 8 did not want the tree to fall on Resident 24. Resident 24 began walking in a fast pace away from the tree, and LPN 8 was going to try and get her to sit down. When LPN 8 approached her, it startled Resident 24. Resident 24 "started fighting me, grabbing at me." LPN 8 was trying to calm her down, but Resident 24 jerked away. "I was hanging onto her in like a hug, but not a tight hug." Afterwards, LPN 8 thought she should have just left it alone, as the decorations weren't that important. By the time LPN 8 got to Resident 24, she was already away from the tree, so she should have just left it alone. LPN 8 thought Resident 24 hit her head on the floor, because when she got up, there was blood coming from her nose. LPN 8 was the only staff member on the unit at the time, as the CNA (Certified Nursing Assistant) on duty was on break.<br><br>The Specialty Unit Responding to Feelings policy was provided by the DON on 5/18/23 at 2:03 p.m. It read, "Things Not To Do: a. Don't argue with the person. This always makes the situation worse. Furthermore, it is important to remember | | | |

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| | that a person with dementia no longer has the ability to be rational or logical to the extent you do. b. Don't order the person around. Few of us like to [sic] bossed around and the person with dementia is no exception. Even when your words are not understood, your tone of voice will be. c. Don't tell the person what he or she can't do. State directions positively instead of negatively. Instead of 'You can't go outside now,' try 'Let's sit down here and look at these pictures.'"<br><br>The Specialty Unit Communication Techniques for Alzheimer's Residents policy was provided by the DON on 5/18/23 at 2:03 p.m. It read, "Approach from the front and at eye level....Most importantly, 'BE PATIENT AND CONVEY LOVE WITH EACH INTERACTION.'"<br><br>The Specialty Unit Behaviors-What Can We Do? policy was provided by the DON on 5/18/23 at 2:03 p.m. It read, "First and foremost, determine who the problem is a problem for. Is it endangering the resident or another resident? Or is it simply annoying you? Is it socially unacceptable? Is it altering the function of the unit or disrupting anyone in any way?...Resisting care-This is often a result of improper approach."<br><br>3.1-37(a) | | | |
| F 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or | | | |

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| | §483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on interview and record review, the facility failed to ensure a resident was free of unnecessary mediations with antibiotic usage for 1 of 1 residents reviewed for antibiotic medications. (Resident 1)<br><br>Findings include:<br><br>The clinical record for Resident 1 was reviewed on 5/16/23 at 10:00 a.m. The diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease (COPD).<br><br>A physician order dated 6/4/22 indicated Resident 1 was to receive 250 milligrams of Azithromycin once a day every Monday, Wednesday and Friday for prevention.<br><br>The June 2022 "Infection Surveillance Data Collection Form" indicated Resident 1's signs and symptoms of the resident's infection was cough and COPD. This was an ongoing prophylactic antibiotic. It did not meet criteria for antibiotic usage. | F 0757 | F757 Drug Regiment is Free from Unnecessary Drugs<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #1's MD was notified on 5/18/2023 regarding medication error of Cefdinir and Azithromycin being given concurrently.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents have the potential to be affected by this alleged deficient practice<br>· All residents with antibiotic orders for the last 30 days will be audited to ensure the order was | 06/05/2023 |

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| | A physician order dated 10/14/22 indicated Resident 1 was to receive 300 milligrams of Cefdinir daily until 10/18/22. Stop Azithromycin while taking Cefdinir. Azithromycin will resume after the completion of Cefdinir.<br><br>The October 2022 "Infection Surveillance Data Collection Form" indicated Resident 1's signs and symptoms of the resident's infection was COPD exacerbation.<br><br>The October 2022 Medication Administration Record (MAR) indicated Resident 1 had received Azithromycin antibiotic on Mondays, Wednesdays, and Fridays 10/3/22 through 10/31/22. The Azithromycin medication had not been stopped on 10/15/22, 10/16/22, 10/17/22, and 10/18/22 as ordered.<br><br>An interview was conducted with Director of Nursing (DON) on 5/18/23 at 2:03 p.m. She indicated the resident does see an outside physician that ordered the prophylactic antibiotic. Normally, the Infection Preventionist would notify the Medical Director (MD) about the prophylactic antibiotic order. The MD would then contact the outside physician/specialist to clarify if it was truly necessary to start a prophylatic antibiotic. She was unable to find documentation the discussion had taken place. Resident 1 has been on the prophylactic a long time and continues receiving Azithromycin Mondays, Wednesdays and Fridays. The residents that have used prophylactic antibiotics are not normally kept on them as long as Resident 1 has been on the preventive antibiotic. Resident 1 had received the Azithromycin and the Cefdinir antibiotics at the same time in October 2022. The Azithromycin had not been stopped on 10/14/22 as ordered. | | followed as directed.<br>· All residents with routine antibiotic orders will have the specialty physician notified to clarify reasoning for routine antibiotic use.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All licensed nurses will be re-educated on the facility policy and procedure Infection Control Surveillance Program" on or before 6/5/2023 (Attachment K)<br>· All licensed nurses will be re-educated on the facility policy and procedure Physician Order Transcription Procedure" on or before 6/5/2023 (Attachment L)<br><br>**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;**<br><br>· The QA tool titled, "Nursing Services Review" will be utilized by the DON or designee 3x weekly for 4 weeks, 1 time weekly for 4 weeks and then monthly thereafter as part of the facility QAPI program. The QA tool titled "INFECTION SURVEILLANCE DATA COLLECTION FORM" Any concerns identified will be | |

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| | 3.1-48(a)(2)(4) | | corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment's F & M) | |
| F 0759 SS=D Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent for 1 of 4 residents observed during medication pass. There were 25 opportunities with 2 errors resulting in an 8% medications error rate. The errors involved 1 resident (Resident 3) in the sample of 4.<br><br>Findings include:<br><br>The clinical record for Resident 3 was reviewed on 5/19/23. Resident 3's diagnoses included, but not limited to, chronic obstructive pulmonary disease (COPD), diabetes type II,, and Alzheimer's disease.<br><br>A physician's order dated 11/2/22 indicated, to give Resident 3 one 2.5 mg(milligram) of Zyprexa (antipsychotic) ODT (orally disintegrating tablet) every Wednesday for dementia with delusions.<br><br>A physician's order dated 11/3/22 indicated to | F 0759 | F759 Free of Medication Error Rts 5 Prcnt or More<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #3's MD was notified on 5/18/23 of resident having Zyprexa crushed and administered as well of not rinsing after inhaling Flovent.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents who take dissolving medications and inhalers that require rinsing after inhalation have the potential to be affected by this alleged deficient | 06/05/2023 |

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| | give Resident 3 one 5 mg Zyprexa tablet ODT on Monday, Tuesday, Thursday, Friday, Saturday, and Sunday and an order for Flovent 110 mcg (micrograms).<br><br>An observation of LPN (licensed Practical Nurse) 6 was conducted on 5/18/23 at 9:29 a.m. LPN 6 was administering Resident 3's medications which included, but not limited to, the Zyprexa and Flovent. The box for the Flovent indicated, to rinse the patients mouth with water and to spit the water out after administering the Flovent. LPN 3 took all the oral medications, including the Zyprexa ODT tablet, and placed them into a plastic sleeve and crushed the medications. She placed the crushed medications into vanilla pudding and administered them to the resident. After taking the crushed oral medications, Resident 3 then inhaled her dose of Flovent and took a sip of water. Resident 3 did not rinse and spit after the inhaler and she swallowed the Zyprexa tablet instead of letting it disintegrate in her mouth.<br><br>An interview with Pharmacist 2 was conducted on 5/18/23 at 10:30 a.m. Pharmacist 2 indicated, Zyprexa ODT should not be administered when crushed and swallowed as that will affect the absorption of the medication.<br><br>An interview with DON (Director of Nursing) conducted on 5/18/23 at 2:12 p.m. indicated, when administering an inhaled medication which indicated a need to rinse and spit after taking the medication, it would not suffice to only take a sip of water and the resident should have been instructed to rinse then spit out the water.<br><br>A Medication Administration Procedure policy was received 5/19/23 at 10:19 a.m. from DON. The | | practice.<br>· All licensed nurses and QMA's will be re-educated on the facility policy and procedure "Medication Administration" and on "Medications not to be Crushed" on or before 6/5/2023. (Attachment N & O)<br>· Each medication cart will have "Medications Not to be Crushed" placed on the medication cart for review if needed by licensed nurses and QMA's.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All licensed nurses and QMA's will be re-educated on the facility policy and procedure Medication Administration" and on "Medications Not to be Crushed" on or before 6/5/2023 (Attachment N & O)<br><br>**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;**<br>· The QA tool titled, "Medication Administration Observation Review Tool" will be utilized by the DON or designee 5x weekly for 4 weeks, 2x weekly for 4 weeks and then monthly thereafter as part of the facility | |

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| | policy indicated, "Altering of medication: Ensure that there is a physician's order stating it is acceptable to crush tablets of open medication capsules and give with food substance. If a medication should not be crushed or altered contact physician for al alternate medication or liquid equivalent."<br><br>3.1-48(c)(1)<br>3.1-48(c)(2) | | QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment P) | |
| F 0825 SS=D Bldg. 00 | 483.65(a)(1)(2)<br>Provide/Obtain Specialized Rehab Services<br>§483.65 Specialized rehabilitative services.<br>§483.65(a) Provision of services.<br>If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-<br><br>§483.65(a)(1) Provide the required services; or<br><br>§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.<br><br>Based on interview and record review, the facility failed to provide a speech evaluation, as ordered by the physician, for a resident requesting a diet | F 0825 | F825 Provide/Obtain Specialized Rehab Services<br>**What corrective action(s) will be accomplished for those** | 06/05/2023 |

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| | upgrade for 1 of 1 resident reviewed for nutrition (Resident 48).<br><br>Findings include:<br><br>The clinical record for Resident 48 was reviewed on 5/16/23 at 8:32 a.m. The Resident's diagnosis included, but was not limited to, dysphagia (trouble swallowing).<br><br>A physician's order, dated 8/14/2020, indicated he was to receive a mechanical soft and no added salt diet.<br><br>A care plan, initiated 8/25/2020, indicated he was at nutritional risk related to being on a mechanically altered and therapeutic diet. He was non-compliant with diet and would eat foods that the family provided, such as pork rinds. He had experienced weight fluctuations. The goal was for him to consume meals of foods and beverages that he selected and for him to be served his diet as ordered. The interventions, initiated 7/14/2020, were to serve his diet as ordered, have him select his own menu, and monitor weight and intake.<br><br>A Speech Therapy Discharge Summary, dated 5/6/21, indicated that he was able to follow safety strategies for safe swallowing with 75% accuracy with moderate verbal cues. He was educated that a mechanical soft diet was the safest to decrease aspiration (food going into lungs) risk.<br><br>A physician's order, dated 1/19/23, indicated speech therapy was to evaluate and treat as indicated. The order was discontinued on 1/25/23.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 3/13/23, indicated he had moderately impaired cognition. | | **residents found to have been affected by the deficient practice;**<br>· Resident #48 had a ST eval completed on 6/5/2023<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents have the potential to be affected by this alleged deficient practice.<br>· 100% audit of all residents' orders will be completed on or before 6/5/2023 to ensure follow up with therapy evals are completed as ordered.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All licensed nurses will be re-educated on the facility policy and procedure "<br>**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;**<br>· The QA tool titled, "Nursing Services Review Tool" will be utilized by the DON or designee 5x weekly for 4 weeks, 2x weekly for 4 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon | |

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| | On 5/16/23 at 8:32 a.m., Resident 48 was observed sitting in his wheelchair in his room. There was a box of individual potato chips bags on his bed. He indicated he wanted to eat hamburgers, but the facility would not give them to him.<br><br>During an interview on 5/18/23 at 9:24 a.m., Resident 48 indicated he had not been seen by speech therapy. He often requested hamburgers and was told he could not have them because he couldn't swallow. He had not has a swallowing test since he had been at the facility.<br><br>During an interview on 5/18/23 at 9:30 a.m.., the Dietary Manager indicated that Resident 48 frequently asked for hamburgers. He was offered mechanical soft (ground up) hamburger on a bun but refused them. He was not safe to have a regular hamburger because he ate so fast.<br><br>During an interview on 5/18/23 at 9:54 a.m., the Therapy Coordinator indicated there was no documentation that a speech eval was completed in January 2023.<br><br>During an interview on 5/18/23 at 11:10 a.m., ST (Speech Therapist) 4 indicated she had screened him in March 2023 and felt he was on the appropriated diet. She was not sure if Resident 48 would be safe to eat a hamburger, it would have to be cooked right so that it was tender. He may be able to if it were cut in half or quarters, but she had not evaluated him, so she could not recommend he received hamburgers that were not mechanically altered. In order to upgrade Resident 48's diet so that he could have hamburger which were not mechanically altered, ST 4 would need to evaluate him and try the hamburger to see if he tolerated it. A Modified | | discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment F) | |

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| | Barium Swallow test would be helpful to determine his swallowing ability.<br><br>During an interview on 5/18/23 at 11:49 a.m., the DON (Director of Nursing) indicated Resident 48 had an order for speech therapy in January 2023. The order had not been properly communicated to the therapy department and had not been completed. Resident 48 frequently ate things like pork rinds, chips, and candy bars. To her knowledge, Resident 48 had not been treated for aspiration pneumonia during his time at the facility.<br><br>On 5/18/23 at 2:05 p.m., the DON provided the New Order policy last updated 3/23/18, which read "... To ensure physician orders are transcribed correctly and carried out per plan by a licensed nurse...Make a progress note to indicate that physician order was obtained and why. Use the note titled 'Communication of new or changed plan of care/ orders' to ensure that appropriate notification is completed..."<br><br>3.1-23(a)(1) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that | | | |

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| | must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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 | | | |

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| | (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>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 maintain an infection prevention and control program by not ensuring: a urinary catheter bag was off of the floor for 1 of 1 residents reviewed for urinary catheter (Resident 14 ); medication cups, water cups, and plastic sleeves which are used to crush medications in were not handled in a manner to prevent staff from placing fingers and/or fingernails inside the cup or a disposable plastic pouch for 2 of 4 residents observed during medication administration (Residents 36, 56, and 3 ); and not performing proper hand hygiene prior to donning and doffing of gloves for 1 of 4 residents reviewed for medication administration (Resident 33)<br><br>Findings include:<br><br>1. An observation of Resident 14 was conducted on 5/16/23 at 10:11 a.m. The bottom of Resident 14's urinary catheter bag was touching the bedside mat which was on the floor next to his | F 0880 | F880 Infection Prevention and Control<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #14 continues with use of a foley catheter and has had no urinary related infections.<br>· LPN #5 was re-educated on 5/18/23 regarding how to properly pick up a medication cup, drinking cup without touching the inside of the cups and hand hygiene.<br>· Resident #36, #56, and #3 all continue to reside at the facility and have no effects of nurse not handling cups and plastic sleeve incorrectly with medication administration.<br>· LPN #6 was re-educated on | 06/05/2023 |

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| | bed.<br><br>An observation of Resident 14 was conducted on 5/17/23 at 9:31 a.m. Resident 14 was sitting in his wheelchair and the bottom of his urinary catheter bag was on the floor under his wheelchair.<br><br>A physician's order dated 8/7/21 indicated, to ensure Resident 14's catheter bag was below his waist, covered, and tubing is not touching the floor.<br><br>Resident 14's most recent care plan was reviewed on 5/17/23. It indicated, Resident 14 required a urinary catheter related to bladder retention. Some of the interventions included, to maintain the urinary bag below bladder level to facilitate urine flow and to provide measures to prevent excessive pulling/tension on catheter tubing.<br><br>A Foley Catheter Care & Maintenance policy was received on 5/17/23 at 11:35 a.m. from ED (Executive Director). The policy indicated, "Placement of Catheter Tubing Procedure...When in bed of wheel chair...position tubing with no tension...ensure bag or tubing is not touching floor."<br><br>2. a. An observation of LPN (Licensed Practical Nurse) 5 administering medications to Resident 36 was conducted on 5/18/23 at 9:01 a.m. When LPN 5 went to grab a plastic medication cup to dispense the resident's medications into she grabbed the medication cup by placing her index finger inside the cup and her thumb on the outside of the cup in a pinching manner. Also, when she went to grab a cup to place water in for the resident to take their medications she grabbed the cup by its rim which is were the resident's mouth would touch when drinking from the cup. | | 5/18/23 on how to handle a plastic sleeve that is used for crushing of medications.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents have the potential to be affected by this alleged deficient practice.<br>· All licensed nurses and QMA's will be re-educated on the facility policy and procedure "Medication Administration" policy and procedure o or before 6/5/2023 (Attachment N)<br>· All licensed nurses and QMA's will be educated on "Safe Practices when handling cups/sleeves on the medication carts" on or before 6/5/2023(Attachment R)<br>· All licensed nurses and QMA's will be educated on "Use of Medical Gloves" policy and procedure on or before 6/5/2023 (Attachment S)<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>· All licensed nurses and QMA's will be re-educated on the facility policy and procedure "Medication Administration" policy and procedure o or before 6/5/2023 (Attachment N) | |

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| | b. An observation of LPN 5 administering medications to Resident 56 was conducted on 5/18/23 at 9:16 a.m. When LPN 5 went to grab a plastic medication cup to dispense the resident's medications into she grabbed the medication cup by placing her index finger inside the cup and her thumb on the outside of the cup in a pinching manner. Also, when she went to grab a cup to place water in for the resident to take their medications she grabbed the cup by its rim which is were the resident's mouth would touch when drinking from the cup.<br><br>c. An observation of LPN 6 administering medications to Resident 3 was conducted on 5/18/23 at 9:29 a.m. LPN 6 dispensed Resident 3's pills into a medication cup then grabbed a disposable plastic pouch used to crush medications in and placed her fingernail inside of the pouch to open the plastic pouch up so she could pour the tablets into the pouch. She then placed the plastic pouch into the crushing tool. After the pills were sufficiently crushed, she again placed her fingernail into the pouch to open it up so she could pour the contents of the pouch into a medication cup.<br><br>3. An observation of LPN 5 administering insulin to Resident 33 was conducted on 5/18/23 at 12:04 p.m. After performing the blood glucose check on Resident 33, LPN 5 walked out of the resident's room, removed her gloves, and preceded to draw up the Humalog to administer to the resident. LPN 5 did not perform hand hygiene after doffing her gloves. After drawing up the required amount of Humalog, she proceeded into Resident 33's room. She donned a pair of gloves and administered the medication. LPN 5 did not perform hand hygiene prior to donning her | | · All licensed nurses and QMA's will be educated on "Safe Practices when handling cups/sleeves on the medication carts" on or before 6/5/2023(Attachment R)<br>· All licensed nurses and QMA's will be educated on "Use of Medical Gloves" policy and procedure on or before 6/5/2023 (Attachment S)<br><br>**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;**<br>· The QA tool titled, "Medication Administration Observation Review Tool" will be utilized by the DON or designee 5x weekly for 4 weeks, 2x weekly for 4 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment P) | |

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|---|---|---|---|
| | 155557 | A. BUILDING 00<br>B. WING | 05/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| MILLER'S MERRY MANOR | 1651 N CAMPBELL ST<br>INDIANAPOLIS, IN 46218 |

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| | gloves. After administering the insulin, LPN 5 exited Resident 33's room, disposed of the syringe, and removed her gloves. She did not perform hand hygiene after leaving the room and doffing her gloves.<br><br>An interview with DON (Director of Nursing) was conducted on 5/18/23 at 2:12 p.m. DON indicated, all medication and/or water cups should be handled so that the part of the cup the resident places their lips on is not contaminated and/or touched nor should fingers or fingernails be placed inside of a medication and/or water cup as well as the disposable plastic pouch used to crush medications.<br><br>A Use of Medical Gloves policy was received on 5/19/23 at 10:19 a.m. from DON. The policy indicated, "Gloves are worn to reduce the likelihood that hands of personnel contaminated with microorganisms form a resident or a fomite (any substance that absorbed and transmits infectious material) can transmit these microorganisms to another resident...hands should be washed initially prior to putting on the gloves...Gloves should be removed and hands washed with soap and water immediately after glove removal."<br><br>3.1-18(a)<br>3.1-18(l) | | | |
| F 0881 SS=D Bldg. 00 | 483.80(a)(3)<br>Antibiotic Stewardship Program<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | | | |

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| | §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>Based on interview and record review, the facility failed to track and monitor antibiotic usage to ensure resident's did not receive prophylactic antibiotics for 1 of 1 residents reviewed for antibiotic medications. (Resident 1)<br><br>Findings include:<br><br>The clinical record for Resident 1 was reviewed on 5/16/23 at 10:00 a.m. The diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease (COPD).<br><br>A physician order dated 6/4/22 indicated Resident 1 was to receive 250 milligrams of Azithromycin once a day every Monday, Wednesday and Friday for prevention.<br><br>The June 2022 "Infection Surveillance Data Collection Form" indicated Resident 1's signs and symptoms of the resident's infection was cough and COPD. This was an ongoing prophylactic antibiotic. The form indicated it did not meet criteria for antibiotic usage.<br><br>The July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, January 2023, February 2023, March 2023, April 2023, and May 2023 Infection Surveillance Data Collection Forms did not include tracking or monitoring of Resident 1's Azithromycin antibiotic.<br><br>A physician order dated 10/14/22 indicated Resident 1 was to receive 300 milligrams of Cefdinir daily until 10/18/22. Stop Azithromycin | F 0881 | F881 Antibiotic Stewardship Program<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>· Resident #1 remains in the facility at this time. The pulmonologist was consulted on 5/23/2023 and the medication will continue to treat Panlobular emphysema and she will continue to follow up with pulmonology as directed. The diagnosis was updated and the Medical Director was also notified.<br>· The INFECTION SURVEILLANCE DATA COLLECTION FORM was updated for June 2023 for ongoing tracking and monitoring.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>· All residents have the potential to be affected by this alleged deficient practice.<br>· 100% audit of all medications currently ordered will be audited to ensure tracking and monitoring of antibiotics is current.<br>**What measures will be put into place and what systemic** | 06/05/2023 |

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| | while taking Cefdinir. Azithromycin will resume after the completion of Cefdinir.<br><br>The October 2022 "Infection Surveillance Data Collection Form" indicated Resident 1's signs and symptoms of the resident's infection was COPD exacerbation.<br><br>An interview was conducted with Director of Nursing (DON) on 5/18/23 at 2:03 p.m. She indicated she was handling the antibiotic stewardship program due to the Infection Preventionist (IP) was on leave. The facility uses Mcgreers to determine if a resident's infection meets the criteria to treat with an antibiotic. If the resident's infection does not meet utilizing labs/x-rays and signs and symptoms the antibiotic was not normally started or if it was started discontinued. Resident 1 does have an outside physician that ordered the Azithromycin antibiotic to be used as a preventive for infection. In the cases, of outside providers ordering prophylactic antibiotics to residents; once aware the IP would notify the Medical Director (MD). The MD would address with the outside physician/specialist about the usage of the prophylactic antibiotic to determine if it was necessary to start. She was unable to provide documentation the discussion took place with Resident 1's outside physician/specialist. The IP should have been tracking and monitoring Resident 1's antibiotic. The resident's antibiotic usage should have been documented on July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, January 2023, February 2023, March 2023, April 2023, and May 2023 infection surveillance forms.<br><br>The "Infection Control Surveillance Program" policy was provided by the Executive Director on | | **changes will be made to ensure that the deficient practice does not recur;**<br>· All Licensed nurses will be re-educated on the “Infection Control Surveillance Program” on or before 6/5/2023. (Attachment K)<br><br>**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;**<br>· The QA tool titled, Infection Control Review Tool will be utilized by the DON or designee 5x weekly for 4 weeks, 2x weekly for 4 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment T) | |

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| | 5/16/23 at 10:35 a.m. It indicated "...1. Purpose: ...To establish an infection control and prevention process for residents residing in the facility...Surveillance components will include Investigation, Clinical records and documentation, on-site monitoring, data analysis, reporting, implementation of program changes as needed. 2. Procedure A. The Initial Infection Assessment located in the electronic medical record (EMR) will be completed by the Charge Nurse when a resident is placed on an antibiotic. B. Daily Infection Assessments will be completed while a resident is receiving an antibiotic or presenting with infection systems. This documentation is completed via a daily infection assessment or the daily Medicare documentation assessment. C. During the course of treatment, and while the resident is receiving an antibiotic the Infection Control Coordinator will review the EMR for Infection Assessments and monitor for appropriate treatment and management of the infection or condition of warranting the use of antibiotics and treatment. D. Each resident be tracked by the Infection Control Coordinator until the course of treatment and symptoms have resolved. This tracking may include reviewing culture reports, progress notes, AM meeting attendance, chart review, walking rounds or direct observations and interview of residents/staff. E. At the end of each month, the Infection Control Coordinator will collect information contained in the infection assessments, and the list this information classified into either a true infection or symptoms requiring treatment per physician or provider assessment and clinical judgement...Individual and group action plans will be developed based upon information from this data collection. 3. Documenting Surveillance data A. Information on the line/listing form will include - I. Resident name. II. Signs and symptoms | | | |

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| | information. III. Infection type, IV. Date signs/symptoms were first noted. V. Any culture or x-ray results. VI. Antibiotic/Antimicrobial name and dosage. VII. Antibiotic/Antimicrobial start and stop date. VIII. Isolation type of required. IX. Verification of true infection/meets infection criteria definition. B. To determine if data is a true infection - a complete review of the infection criteria guideline must be completed..."<br><br>The Antibiotic Stewardship program was provided by Executive Director on 5/16/23 at 10:35 a.m. It indicated "...It is the policy of the Miller's Health Systems, Inc. to utilize an Antimicrobial and Antibiotic Stewardship Program based upon the guidance and recommendations of the CDC [The Centers for Disease Control and Prevention" and within CMS [The Centers for Medicare & Medicaid Services] proposed guidelines...On a monthly basis, antibiotic/antimicrobial use will be reviewed by the Consultant Pharmacist, ICPO [Infection Control and Prevention Officer], DON and Medical Director. Results of this review will then be presented to the QAPI [Quality Assurance and Performance Improvement] meeting as appropriate. If this review finds that a particular clinician is prescribing antibiotics outside of the appropriate use indicators, the Pharmacy Consultant or Medical Director at his/her discretion may inform the associate clinical of the need for further compliance need. Continued non-compliance may result in a need to alter provider privileges in the facility. Any discrepancies of the review will also be included in the QAPI program log and interventions initiated to demonstrate a good faith effort to correct inappropriate use of antibiotics..." | | | |