STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 00 B. WING	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILNER COMMUNITY HEALTH CARE	370 E MAIN ST ROSSVILLE, IN 46065

(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 was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00439112. Complaint IN00439112-No deficiencies related to the allegations are cited. Survey dates: August 12, 13, 14, 15 and 16, 2024. Facility number: 000299 Provider number: 155676 AIM number: 100286940 Census Bed Type: SNF/NF: 47 Residential: 12 Total: 59 Census Payor Type: Medicare: 5 Medicaid: 37 Other: 5 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 20, 2024.	F 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard G Jackson	Administrator	08/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure a new Preadmission Screening and Resident Review (PASARR) was completed when a new mental health diagnosis or a new psychiatric medication was added for 2 of 2 residents reviewed for PASARR. (Resident 31 and 34) Findings include: 1. The clinical record for Resident 31 was reviewed on 8/14/24 at 10:42 a.m. The diagnoses included, but were not limited to, pain, major depressive disorder, and generalized anxiety disorder. A PASARR level I screen, dated 9/17/20, did not include a diagnosis of depression or anxiety. There were no medications listed on the PASARR. A social services progress note, dated 10/10/22, indicated the resident was taking Cymbalta (an anti-depressant medication) 60 milligram (mg) daily and had depression and anxiety. The diagnosis of major depressive disorder was	F 0644	1. Residents 31 and 34 had PASSR completed immediately. 2. Performed audit on all residents PASSR to assure all are correct and complete. 3.PASSR audits upon admission and every 3 months for new diagnosis or newly prescribed psychotropic medications. Continue quarterly PASSR audits with MDS scheduling to ensure all diagnosis and medications are captured. 4. Audits will be reviewed during QAPI meetings for 6 months to ensure compliance.	09/09/2024

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	added to the resident's list of diagnoses on 11/14/22 and again on 1/17/23. The diagnosis of generalized anxiety disorder was added to the resident's diagnosis list on 12/8/22. A physician's order, dated 4/20/21, indicated to give Cymbalta 60 (mg) once a day on Monday through Saturday. A physician's order, dated 2/20/23, indicated to give Cymbalta 40 mg every Sunday. A psychiatry progress note, dated 8/10/23, indicated Resident 31 had a diagnosis of recurrent moderate major depressive disorder and to continue Cymbalta as prescribed. A gradual dose reduction of the Cymbalta was denied due to symptom instability. A psychiatry progress note, dated 2/8/24, indicated the resident was taking Cymbalta with a diagnosis of major depressive disorder. A social services progress note, dated 7/1/24, indicated the resident was referred for ongoing treatment of anxiety and depression. A care plan, initiated on 10/9/20 and revised on 8/9/24, indicated the resident was at risk of having symptoms of depression and was at risk for side effects related to her antidepressant medication. During an interview, on 8/14/24 at 3:00 p.m., the Social Services Director indicated she had missed the diagnoses of depression and anxiety and anti-depressant medication for the resident was not listed on the original PASARR. She indicated she should have initiated a new PASARR when the diagnoses and medication were added originally.2. The clinical record for Resident 34			

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	was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, general anxiety disorder, major depressive disorder, and cognitive communication deficit. A PASARR level 1 screen, dated 3/25/24, indicated no level 2 was required. No serious mental illnesses were present and the current mental health diagnoses included anxiety disorder. If changes occurred or new information refuted these findings, a new screen must be submitted. A PASARR level 1 screen, dated 4/15/24 indicated the level 1 was negative. No signs of serious mental illnesses were present and the current mental health diagnoses included anxiety disorder. If a status change occurred, then an updated level 1 must be submitted. A facility diagnosis report indicated the resident had major depressive disorder with an onset date of 4/1/24. The PASARR did not include the resident's diagnosis for major depressive disorder. A psychiatry progress note, dated 8/8/24, indicated the resident had a diagnosis of major depressive disorder. During an interview, on 8/13/24 at 1:09 p.m., the Social Services Director (SSD) indicated she did not know the resident had the diagnosis of major depressive disorder. During an interview, on 8/16/24 at 12:29 p.m., the SSD indicated she did not have a PASARR policy but followed the Indiana regulations.			

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	3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
F 0684 SS=E 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. Based on observation, interview and record review, the facility failed to follow the physician ordered hold parameters for medications, to notify the physician of a high blood sugar reading as ordered, and to monitor and document bowel movements for 4 of 4 residents reviewed for quality of care. (Resident 34, 44, 25 and 40) Findings include: 1. The clinical record for Resident 34 was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, chronic diastolic heart failure, major depressive disorder, essential hypertension, and stage 3 chronic kidney disease. A physician's order, dated 4/3/24, indicated to give metoprolol (a medication used to treat high blood pressure) 50 mg (milligram) twice daily. Hold if the resident's pulse was below 60 and/or the systolic blood pressure (top number on a blood pressure reading) was below 115. A physician's order, dated 5/9/24, indicated to give midodrine HCL (a medication used to treat	F 0684	1. Resident 34 physician notified of medication error. Resident 44 physician notified of last 2 weeks of blood sugars. Resident 25 and 40 bowel sounds assessed, and both had BMs by 8/8 2. BM report ran immediately to identify any other residents in need of bowel protocol. Will audit all B/P and blood sugar medications to review that the physician recommended parameters are being followed and physician notified of any irregularities. 3. Nurses/QMA's will be in-serviced on policy and procedures for holding medications due to ordered parameters and physician notification. Also, all nursing staff will be reeducated on bowel protocol. Continue to audit all B/P	09/09/2024

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	orthostatic blood pressure) 5 mg three (3) times a day. Hold for a systolic blood pressure greater than 140. A physician's order, dated 4/2/24, indicated to take torsemide (a diuretic medication) 40 mg twice per day. Hold if the systolic blood pressure was less than 110. An electronic medication administration record indicated the following: On 6/11/24 in the a.m., the systolic blood pressure was 94. Metoprolol 50 mg was administered. On 6/24/24 in the p.m., the systolic blood pressure was 110. Metoprolol 50 mg was administered. On 7/3/24 at 4:00 p.m., the systolic blood pressure was 105. Torsemide 40 mg was administered. On 7/6/24 at 8:00 a.m., the systolic blood pressure was 141. Midodrine 5 mg was administered. On 7/21/24 in the p.m., the systolic blood pressure was 84. Metoprolol 50 mg was administered. On 8/5/24 at 8:00 a.m., the systolic blood pressure was 145. Midodrine 5 mg was administered. On 8/6/24 in the a.m., the systolic blood pressure was 112. Metoprolol 50 mg was administered. On 8/7/24 in the p.m., the systolic blood pressure was 112. Metoprolol 50 mg was administered. During an interview, on 8/14/24 at 1:28 p.m., the Assistant Director of Nursing (ADON) indicated the medications were administered on those dates due to the nurses thought both the blood pressure and the pulse had to be out of the parameters to hold the medications. The orders needed clarified. 2. The clinical record for Resident 44 was reviewed on 8/13/24 at 2:23 p.m. The diagnoses included, but were not limited to, chronic systolic heart failure, type 2 diabetes mellitus, stage 3 chronic		medications and blood sugars with parameters weekly for the next three weeks, then random audits in the next three months to establish continued compliance and assess need for further staff education. To be printed daily, by the nurse and signed, then turned into the DON/ADON when bowel protocol on those residents is completed. BM added to clinical meeting minutes report to be reviewed Monday through Friday in morning clinical meeting. 4. Audits will be reviewed in QAPI for six months to assure compliance or need for further intervention.	

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	kidney disease, dysuria, and primary adrenocortical insufficiency. A physician's order, dated 6/11/24, indicated to take lispro insulin per sliding scale and if the blood sugar was above 450 or less than 60 then to notify the physician. A physician's order, dated 7/28/24, indicated to take 22 units of glargine insulin at bedtime. Per the resident's request, please check blood sugar. The electronic medication administration record indicated, on 8/9/24, the resident's blood sugar was 500. There was no documentation in the clinical record to indicate the physician was notified. During an interview, on 8/15/24 at 2:52 p.m., the Director of Nursing (DON) indicated there were no hold orders related to checking the blood sugar at night, but the doctor should have been notified of the high blood sugar.3. The clinical record for Resident 25 was reviewed on 8/13/24 at 11:20 a.m. The diagnoses included, but were not limited to, delusional disorder, unspecified dementia, and constipation. A physician's order, initiated on 5/29/18, indicated to give docusate sodium and senna 50 milligrams-8.6 milligrams (mg) as needed twice a day for constipation. A care plan, initiated 8/2/22, indicated Resident 25 was at risk for constipation related to medication use and increased reminders to eat and drink. An intervention indicated to monitor the resident's bowel movements and to administer the ordered medication(s) as needed.			

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	The resident did not have a documented bowel movement from 7/27/24 to 8/7/24 (12 days). There was no documentation of an abdominal assessment in the record. There was no documentation to show the resident was provided the as needed medication to promote a bowel movement in the record. 4. The clinical record for Resident 40 was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, and constipation. A physician's order, initiated 5/9/24, indicated to give Miralax (a medication to promote bowel movement) 17 grams in eight (8) ounces of water as needed every day for constipation. The resident did not have a care plan for constipation in the record. The resident did not have a documented bowel movement from 7/19/24 to 7/22/24 (4 days) and 7/27/24 to 7/30/24 (4 days). There was no documentation of an abdominal assessment in the record. There was no documentation to show the resident was provided the as needed medication to promote a bowel movement in the record. During an interview on 8/15/24 at 9:08 a.m., RN 3 indicated if a resident did not have a bowel movement within 24 hours, the resident or CNA were asked if they had a bowel movement, after 48 hours of no bowel movement the resident was put on the list. At 48 to 72 hours, the nurse would			

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	check with the CNA to ensure they did not forget to chart a bowel movement. The nurse would then perform and chart a bowel/abdominal assessment and treat the resident (provide a medication to promote a bowel movement). The nurses were responsible to check the bowel movement list. During an interview, on 8/15/24 at 11:01 a.m., the Assistant Director of Nursing indicated no assessments for the residents had been completed or documented. The bowel movements had not been documented on the days reviewed and the residents were not given medications to promote a bowel movement. The staff should have completed the assessments. A current facility policy, titled "Medication Administration," dated as last reviewed 2/10/16 and received from the Assistant Director of Nursing on 8/16/24 at 2:00 p.m., indicated "...Read each medication order entirely...Read and follow any special instructions written on labels...." A current facility policy, titled "Change of Condition Notification," dated as last revised 3/14/17 and received from the Assistant Director of Nursing on 8/16/24 at 2:00 p.m., indicated "...It is the policy of this facility to notify the...Resident's Physician...when there is a change in the Resident's condition...Areas that require notification of the Physician...Hypo/hyperglycemic (high/low blood sugar) episodes...." A current facility policy, titled "POLICY AND PROCEDURE FOR MONITORING BOWEL MOVEMENTS," dated as last reviewed 1/30/16 and received from the Assistant Director of Nursing on 8/15/24 at 11:01 a.m., indicated "...Nurses are to observe for any problems with			

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	elimination such as...A resident's abdomen is bloated or swollen and they have not had a bowel movement in the last three days...At the beginning of each noc (night) shift, the nurse will check...for residents have no BM (bowel movement) in 72 hours and add to BM list...Those listed on the BM list will be given a laxative on the Day shift...." 3.1-37(a)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to ensure an accurate bed rail assessment was completed for 1 of 1 resident reviewed for bed rails. (Resident 102)	F 0700	1. Resident 102 bed rail assessment immediately completed accurately.	09/09/2024

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	Finding includes: During an observation, on 8/12/24 at 7:49 a.m., Resident 102 was observed to have bilateral (both sides) bed rails at the head of the bed. The clinical record for Resident 102 was reviewed on 8/14/24 at 11:09 a.m. The diagnoses included, but were not limited to, aphasia following a cerebral infraction (stroke), hemiparesis and hemiplegia (weakness and paralysis to one side of the body), and hypertension. A facility document, titled "Bed Rail Appropriateness assessment," dated 8/6/24, indicated the resident did not use bed rails to promote independent mobility, he was not able to push himself away from the rail if he rolled against it and he did not have a medical reason which required bed rails. During an interview, on 8/15/24 at 12:07 p.m., the Director of Nursing indicated the resident should have had a new assessment completed. A facility policy, titled "Bed Rail Policy," updated 5/6/21 and received from the Director of Nursing on 8/15/24 at 12:07 p.m., indicated "...If resident and or POA (Power of Attorney) and facility feel bed rails might benefit resident a bed rail assessment will be done...." 3.1-45(a)		2. All resident bed rail assessments audited for accuracy. 3. Nurses in-serviced on bed rail policy and bed rail assessments will be audited for accuracy for six months. 4. Assessments reviewed in QAPI for six months to assure no further intervention necessary.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently			

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure refrigerated medications in a multidose bottle had an open date, failed to ensure a multidose supplement had a resident name/label and failed to ensure a controlled substance had an open date in 2 of 2 medication carts and 1 of 1 medication refrigerators. Findings include: 1. During an observation of the Talyst (automated medication machine) room, on 8/13/24 at 12:31 p.m., a 100-milliliter bottle of gabapentin 250 mg/5 ml (milligram to milliliter) was found, in the refrigerator, with approximately 10 ml remaining.	F 0761	1. Resident 2, 102 and incorrectly identified resident 26 had labeling dating corrected immediately (no resident 26 was listed by State; however, resident 26 was identified during the survey process). 2. All medication carts were audited for any other missing dates/errors with labeling. 3. All nurses and QMA's will be in-serviced on policy for medication labeling. Cart audits will be done to check labeling of medications weekly for three	09/09/2024

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	The bottle did not have a date to indicated when it had been opened. During an interview, on 8/13/24 at 12:33 p.m., the Director of Nursing indicated the medication should have had an open date. The record for Resident 102 was reviewed on 8/14/24 at 11:09 a.m. The diagnoses included, but were not limited to, aphasia following a cerebral infraction (stroke), hemiparesis and hemiplegia (weakness and paralysis to one side of the body), and hypertension. A physician's order, initiated on 4/22/24, indicated to give gabapentin 250 mg/5 ml twice a day. 2. During an observation, on 8/13/24 at 12:40 p.m., the "A" hall medication cart was found to have a bottle of cherry flavored Prostat (liquid protein) which had been previously opened. The bottle did not indicate which resident was on the protein supplement. The clinical record for Resident 2 was reviewed on 8/16/24 at 9:07 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hyperlipidemia, and heart failure. A physician's order, initiated on 8/13/24, indicated to give Prostate 30 ml daily. The order had a start time of 2:32 p.m., on 8/13/24. 3. During an observation, on 8/13/24 at 12:45 p.m., the "East End" medication cart was found to have a 15 ml bottle of morphine sulfate (a narcotic pain reliever), without an open date. A sticker on the bottle and box indicated to discard the medication 90 days after opening. There was 12 ml left in the bottle.		months. 4. Audits reviewed by QAPI for three months to assess need for further intervention.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 00 B. WING	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILNER COMMUNITY HEALTH CARE	370 E MAIN ST ROSSVILLE, IN 46065

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	During an interview, on 8/13/24 at 12:45 p.m., QMA 1 indicated the bottle should have had an open date. The clinical record for Resident 26 was reviewed on 8/14/24 at 10:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes, anxiety, and fibromyalgia. A physician's order, initiated 4/5/24, indicated to give morphine sulfate 0.25 ml at bedtime. A current facility policy, titled "Storage of Medications," dated 2023 and received from the Director of Nursing on 8/14/24 at 8:30 a.m., indicated "...Refrigerated medications are kept in...labeled containers...Expiration Dating...Once opened, these will be good to use until the manufacturer's expiration date is reached unless...the manufacturer has specified a usable life after opening...When the original seal of a manufacturer's container or vial is initially broker, the container or vial will be dated by nursing...." A current facility policy, titled "Storage of Medications," dated 2023 and received from the Director of Nursing on 8/14/24 at 8:30 a.m., indicated "...Resident-specific nonprescription medications...that are not labeled by the pharmacy are...identified with the resident's name...." 3.1-25(j) 3.1-25(l)(1) 3.1-25(m)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	Submission of this Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 00 B. WING	08/16/2024

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	Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00439112. Complaint IN00439112 - No deficiencies related to the allegations are cited. Survey dates: August 12, 13, 14, 15 and 16, 2024. Facility number: 000299 Residential Census: 12 Milner Community Health Care was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on August 20, 2024.		Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	