STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155557	A. BUILDING 00 B. WING	10/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387115, IN00387117, IN00387119, IN00382900, IN00378572, IN00390910 and IN00382432. Complaint IN00382900 - Unsubstantiated due to lack of evidence. Complaint IN00387115 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00387117 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00387119 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00382432 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00378572 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00390910 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 3, 4, and 5, 2022 Facility number: 000500 Provider number: 155557 AIM number: 100266220 Census Bed Type: SNF/NF: 50 SNF: 15 Total: 65	F 0000	Please accept this Plan of Correction for complaint survey ending 10/5/22 as the facilities credible allegation of compliance.	

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

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	Census Payor Type: Medicare: 3 Medicaid: 50 Other: 12 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 2022			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect residents from physical abuse for 3 of 3 residents reviewed for abuse, resulting in emergency room visits, a pelvic fracture, and emotional distress. (Residents B, N, and W) Findings include: The clinical record for Resident W was reviewed on 10/3/22 at 2:00 p.m. The diagnoses included,	F 0600	**F600** · **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident W was relocated to a new facility on 6/6/22. · **How other residents having the potential to be**	10/19/2022

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	but were not limited to, dementia with behavioral disturbance. He was readmitted to the facility on 3/9/22 after an inpatient psychiatric stay. The clinical record for Resident N was reviewed on 10/3/22 at 11:03 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. The clinical record for Resident B was reviewed on 10/3/22 at 2:30 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbance. The investigative file into a 3/29/22 incident between Resident W and Resident N was provided by the Administrator on 10/3/22 at 11:03 a.m. The Nursing Occurrence Initial Assessment for Resident W indicated Resident W took his house slipper off and hit Resident N in the right arm. The undated CNA (Certified Nursing Assistant) 5 statement, via interview by the previous Administrator, was included in the investigative file. It read, "I was walking [name of Resident N] when [name of Resident W] came up to us. I was trying to walk [name of Resident N] to him [sic] room. When [name of Resident W] came up and I asked what he needed. I was still walking [name of Resident N] and out [name of Resident W] took his shoe off and hit [name of Resident N] in the arm. I asked [name of Resident W] to head to his room. He had no problem heading to his room. Residents were separated at this time." The 4/4/22 follow up report, included in the investigative file, indicated the residents were immediately separated and 15 minute checks had been discontinued. One to one (1:1) supervision		**affected by the same deficient practice will be identified and what corrective action will be taken;** Any resident residing on the facilities memory care unit had the potential to be affected by this alleged deficient practice. Resident W was relocated to a new facility on 6/6/22. · **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff will be re-educated on "The Abuse Prohibition, Reporting, and Investigation" policy on or before 10/19/2022. (Attachment A) · **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON or other designee will be responsible to complete the QA tool "**Abuse Review**" will be used to monitor for compliance. Tool will be completed 5x a week for 4 weeks, then 3x a week for 4 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	

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	was being provided to Resident W. Neither resident was able to recall the events. Resident W was administered as needed medication which worked to calm him. The facility was looking for alternative placement for Resident W. The investigative file into a 4/4/22 injury of unknown origin for Resident N was provided by the Administrator on 10/3/22 at 11:03 a.m. The 4/4/22 Nursing Occurrence Initial Assessment for Resident N, included in the file, read, "CNA [name of CNA 6] reported resident with a swollen and split lib [sic.] This nurse assessed a swollen lower lip with dried close area that likely had bled some time ago." The 1:1 supervision logs for Resident W were provided by the NC (Nurse Consultant) on 10/4/22 at 2:40 p.m. They indicated he was placed on 1:1 supervision on 4/4/22 at 5:00 p.m. An interview was conducted with the Administrator on 10/5/22 at 10:30 a.m. She indicated he was placed on 1:1 supervision on 4/4/22 because, at the time, it was suspected Resident W may have been involved in Resident N's swollen, bloody lip. The 4/12/22 follow up report to the 4/4/22 incident, included in the investigative file, indicated the facility was unable to determine the root cause of injury to Resident N's lip. Resident N wore a facemask for CPAP (continuous positive airway pressure) while sleeping or napping, and his daughter believed that he may have bit his lip. The 4/5/22 psychological NP (nurse practitioner) note indicated Resident W was being sent out to a local hospital with unpredictable, severe verbal, physical agitation, wandering, and high risk for		in the facility Quality Assurance 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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	elopement. The 4/6/22 nurse's note indicated he returned from the hospital and was placed on 1:1 supervision upon return. The investigative file into a 4/22/22 incident between Resident W and Resident B was provided by the Administrator on 10/3/22 at 11:03 a.m. The 4/22/22 Nursing Occurrence Initial Assessment for Resident W, included in the investigative file, read, "Resident had encounter with another dementia resident and pushed her down and she fell to the floor." The 4/22/22 Occurrence Investigation for Resident B, included in the investigative file, read, "Resident was in the hallway near the dining room and other resident pushed her and she fell on the floor." CNA 7 was present at the time. Resident W pushed Resident B. Resident B was sent to the hospital. There was no statement or interview statement of CNA 7 in the investigative file and she was unavailable for interview. The 4/28/22 follow up incident report to the 4/22/22 incident indicated it had been concluded that Resident W could have pushed Resident B out of his room, causing her to lose her balance and fall to the floor. After Resident B was sent to the emergency room for further evaluation, she returned with no initial findings. The following 2 days, Resident B complained of pain in her pelvic region and was transferred to the emergency room on 4/24/22 for further evaluation where a pelvic fracture was identified. Resident W remained on 1:1 supervision since the 4/22/22 incident and was being evaluated for transfer to another location.			

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	The 4/24/22 hospital notes for Resident B read, "...presented to the [name of hospital] emergency department with a chief complaint of leg pain. Patient was nonverbal with limited interaction with stimuli. Collateral information was obtained from nursing home [name and title of LPN-Licensed Practical Nurse 8.] Discussed patient having a fall that occurred on 04/22 and was sent to the ED [emergency department] for workup. Patient was then discharged back to facility given no acute fracture seen on x-ray imaging at that time. Patient continued to endorse pain to right buttocks and right hip. Patient able to communicate in small phrases and guttural noises....Assessment/Plan: ...Pelvic Fracture Initial fall 4/22, 4/24 CT pelvis demonstrates nondisplaced fractures involving the lateral superior aspect of the right superior pubic ramus and nondisplaced fracture of the mid inferior right pubic ramus. Patient facility continued to endorse pain to right buttock and right hip...Fracture likely inoperable given age." The 4/26/22 psychological NP note for Resident W read, "...was notified yest [yesterday] that he has been physically aggressive toward female peer. No triggers, so random. Staff have been seeking in pt [patient] psyche. No one will take him." Two inpatient psychiatric facility locations felt Resident W was "too aggressive for their units at this time." They discussed the process for a state hospital to which staff were reaching out. "Plan: 1. No med [medication] changes 2. Cont [Continue with one on one, wander gd [guard,] new room 3. See next wk [week] if here." On 10/4/22 at 2:40 p.m., the NC provided a timeline of Resident W's stay at the facility. It indicated he was on 1:1 supervision from 4/23/22 through his discharge on 6/6/22.			

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	The investigative file into a 6/5/22 incident between Resident W and Resident N in the hallway was provided by the Administrator on 10/3/22 at 11:03 a.m. The file included a 6/5/22 written statement from QMA (Qualified Medication Aide) 9 that read, "I [name of QMA 9] got up to check on resident. I then seen [name of Resident W] put his hand down. [Name of Resident W] has just got done hitting [name of Resident N] in the eye because his eye was bleeding. I then got the CNA to help me break it up but then [name of Resident W] came walking up to me saying [name of Resident N] was talking crazy. I then notified the nurses and they came." The file included a 6/6/22 interview statement with QMA 9, conducted by the NC. It read, "[Name of Resident N] had been out wandering the hall way which he does normally. She reports she could hear someone talking (cussing 'what did you say mother f*****?'). She responded coming from the med cart which was parked near the nurses station. [Name of Resident N] was at the end of the hall near [name of Resident Y's] room where [name of Resident W and Resident N] were near each other. [Name of QMA 9] never seen physical contact but seen blood under [name of Resident N's] right eye. The residents were immediately separated. [Name of QMA 9] states when [Name of Resident W] was asked what happened he said 'He was talking crazy' [Name of QMA 9] then alerted the charge nurse [name of LPN 10] to come and assess." The file included an undated written statement from CNA 10. It read, "On 6/5 QMA came to come get me to help break up fight between [name of			

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	Residents W and N] and when I came around the corner where they were they were hitting each other until [name of Resident N] walked away. We then kept them separated until the nurse came." QMA 9 and CNA 10 were unavailable for interview. An interview was conducted with the MCC (Memory Care Coordinator) on 10/4/22 at 12:22 p.m. She indicated 1:1 supervision meant the aide assigned would do everything for the resident all day and was not assigned to any other residents. The aide assigned was to remain by the resident. She was uncertain how the 6/5/22 incident between Resident W and Resident N occurred. An interview was conducted with the NC, DON (Director of Nursing,) and Administrator on 10/5/22 at 10:30 a.m. The NC indicated Resident W was assigned to receive 1:1 supervision from 4/23/22 through his 6/6/22 discharge from the facility. CNA 10 was assigned to provide 1:1 supervision on 6/5/22 and was uncertain who specifically was providing 1:1 supervision at the exact time of the 6/5/22 incident. They'd tried to get a hold of CNA 10, but were unsuccessful, as she was agency staff. The NC and Administrator agreed, based on QMA 9 and CNA 10's statements that it seemed as though QMA 9 left Residents W and N in the hallway to retrieve help from CNA 10 and upon return the residents were physically hitting each other. The Abuse Prohibition, Reporting, and Investigation policy was provided by the Administrator on 10/3/22 at 11:00 a.m. It read, "It is the policy of [name of facility] that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment,			

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	and involuntary seclusion....Physical Abuse-A willful act against a resident by another resident, staff, or other individuals. Examples: hitting,, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper restraints." This Federal Tag relates to Complaint IN00378572. 3.1-27(a)(1)			
F 0684 SS=G 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 interview and record review, the facility failed to timely address a resident's change of condition for 1 of 3 residents reviewed for hospitalization. This resulted in delayed hospitalization for a resident exhibiting signs and symptoms of a stroke. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/3/22 at 11:15 a.m. The resident's diagnoses included, but were not limited to, hemiplegia and heimparesis following nontraumatic intracerebral hemorrhage (stroke) affecting right dominant side and Covid-19. The resident was admitted on	F 0684	**F684** · **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident D no longer resides in the facility. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;**	10/19/2022

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	4/12/22. The Quarterly MDS (Minimum Data Set) assessment dated 7/19/22, indicated Resident D was cognitively impaired. A care plan dated 4/12/22 indicated "Pain: I [Resident D] have potential: for pain/discomfort related to my diagnosis of CVA [Cerebrovascular accident] (stroke) with hemiparesis....Interventions:...Notify MD [medical doctor] as needed..." A care plan dated 4/22/22 indicated "Cognition: I have cognitive impairments related to: having notable variations of cognition from day to day or throughout the day due to my medical condition...Interventions...Give resident two choices when presenting decisions...Notify physician as needed. Observe and report changes in cognitive status. An interview was conducted with Family Member (FM) 2 on 10/3/22 at 3:42 p.m. She indicated during a phone conversation with Resident D on the evening of 7/25/22 at approximately 6:30 p.m.; she had noticed the resident was talking "gibberish." Resident D was not making any sense when she was talking. Prior to the conversation that day, the resident was able to speak and answer questions. FM 2 called the facility and had spoken to Resident D's nurse, License Practical Nurse (LPN) 1. At that time, she informed LPN 1, Resident D was showing signs of having another stroke and wanted her to be sent to the hospital. She then went to the facility. The resident had not been transferred to the hospital. FM 2 went to the resident's room and observed Resident D in a lot of pain due to a headache, and she felt something was wrong with the resident.		All resident residing I the facility had the potential to be affected by this alleged deficient practice. A 100% audit will be completed on or before 10/19/2022 for resident condition changes to ensure compliance with company policy and procedure. · **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nurses will be re-educated on the “Physician & Family Notification of Change of Condition” policy on or before 10/19/2022 (Attachment C) · **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON or other designee will be responsible to complete the QA tool “**Physician and Family Notification Review**” will be used to monitor for compliance. Tool will be completed 5x a week for 4 weeks, then 3x a week for 4 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	

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	She notified LPN 1 and asked again for the resident to be transferred to the hospital for evaluation. The staff did not show any urgency with sending the resident out. Resident D was transferred to the hospital. She did have another stroke. A physician order dated 4/12/22 indicated the resident was to receive 2 tablets of 325 milligrams of Tylenol as needed every 4 hours for pain. The July 2022 Medication Administration Record (MAR) indicated Resident D on 7/25/22 at 6:30 p.m., had a pain score of 7; utilizing a pain scale from 1 being the least amount of pain to 10 being the most amount of pain. The MAR was documented at that time, the resident had received 2 tablets of 325 milligrams of Tylenol by LPN 1, and it was ineffective. A change of condition document dated 7/25/22 at 6:37 p.m., indicated Resident D had "...Pain (uncontrolled), per [FM 2]: slurred speech, altered mental status. This started on 7/25/22 Since this started it has gotten: [marked with a checkmark] stayed the same...Vital signs: 137/91 [blood pressure] pulse: 82 RR: [respirations] 18, Temp [temperature] 98.2...Resident Evaluation: Mental Status Evaluation (compared to baseline;...) [marked with a checkmark] Increased confusion or disorientation...Pain Evaluation. Does the resident have pain? [marked with a checkmark] yes. The pain? [marked with a checkmark] worsening of chronic pain. Intensity of pain (rate on a scale 1-10 with 10 being the worse): [documented as an] 8..Neurological Evaluation: ...Describe symptoms or signs" per daughter: slurred speech...Review and notify: primary care clinician notified: [no documentation noted]..."		in the facility Quality Assurance meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days (Attachment D)	

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	Resident D's clinical record did not indicate the medical provider was notified of the resident's change of condition at 6:30 p.m. A transfer to hospital document completed by LPN 1 dated 7/25/22 at 9:00 p.m., indicated medical provider notified. "...Reason for transfer:...extreme headache with no relief with pain meds [medications] - [FM2] requesting her to go...usual mental status: A&O [alert and oriented]..." An interview was conducted with LPN 1 on 10/3/22 at 2:18 p.m. She indicated Resident D did have a complaint of a headache on 7/25/22, but she was positive with COVID-19. Headaches are a symptom with COVID-19. She had administered Tylenol to the resident, but it was ineffective. She was not familiar with Resident D. The resident's change of condition was based on what FM 2 had reported to her during a phone call. LPN 2 had not notified the medical provider at that time as she should have. An interview was conducted with Physician 3 on 10/4/22 at 10:16 a.m. She indicate LPN 1 should not have delayed notifying her office of Resident D's change of condition. The hospital records dated 7/25/22 at 9:42 p.m., indicated Resident D had complaints of "severe headache". Resident D was in "...ED [emergency department] for evaluation of increase in speech difficulty onset about 3 hours ago today. Pt [patient] has associate headache and she describes it as "worst headache ever". Per medics these are the same symptoms and pt described in her last prior stroke. Pt has right sided deficits from the prior stroke. LKN [last known normal] was at 18:30 [6:30 p.m.] today. history is limited due to Altered Mental Status...Review of			

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	155557	A. BUILDING 00 B. WING	10/05/2022

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

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	systems...Neurological: Positive for speech difficulty and headaches...Triage Vital Signs - Temp: 98.2 °F [Fahrenheit], Pulse: 100, Resp: 29, BP: 132/94, SpO2 [oxygen saturations]: 98 %...Physical Exam:...Comments: Holding head and saying "pain"...Doesn't answer questions appropriately, just says "pain"...MEDICAL DECISION MAKING: Patient...presenting to the emergency department today for evaluation of possible stroke-like symptoms. Patient normally is able to communicate but had increasing aphasia [disorder how to communicate] at her facility with increased rightsided deficits more than normal. She does have a history of a hemorrhagic stroke previously. Patient also complaining of a headache. Patient was evaluated immediately upon arrival as a potential code stroke. Given patient is 3 hours from onset of her symptoms I did initiate code stroke to evaluate for large vessel occlusion [blockage]. She is not a tPA [tissue plasminogen activator] candidate secondary to history of hemorrhagic CVA...Case discussed with the hospitalist service and patient accepted for admission for further evaluation and care. Patient admitted in stable condition...presents to hospital with complaints of aphasia and headache. Headache started earlier today. Patient is describing this as the "worst headache ever". It is sharp, stabbing, frontal and nonradiating. Notes some expressive aphasia as well that started about 630. She knows what she wants to say, but is having a hard time putting the words together. Patient has a history of a hemorrhagic stroke in 03/2022 and she reports symptoms are similar to that episode. Patient does have baseline right-sided weakness from the previous stroke. ...Date of Discharge: July 31, 2022...Admission Diagnosis:Transient speech disturbance...Discharge Diagnosis: Principal Problem: CVA (cerebral vascular			

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	accident)...Consults: neurology...MRI significant for subacute infarct [stroke] in the left medial temporoparietal lobe...[part of the brain] Patient also was found to have deep vein thrombosis [blood clot] in the right upper extremity,...Patient was discharged to [name of rehabilitation facility]..." A "Physician & Family Notification of Change of Condition" policy was provided by the Director of Nursing on 10/3/22 at 4:00 p.m. It indicated "...Physician & Family Notification of Condition Changes: 1. Purpose A. To keep the physician, resident and family appraised of all condition changes...3. Procedure: A. Telephone I. Telephone notification is required for all emergencies, all condition changes...II. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan. III. Notify the primary physician during regular office hours and the on-call or alternate physician during closed office hours or when the physician is not available. IV. Document the information reported to the physician in the nurses notes including the time and date of notification. be thorough and explicit..." This federal tag relates to Complaint IN00390910. 3.1-37(a)			