STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00424441 and IN00424474. Complaint IN00424441 - No deficiencies related to the allegations are cited. Complaint IN00424474 - No deficiencies related to the allegations are cited. Survey dates: January 24, 25, 26, 29, and 30, 2024. Facility number: 000089 Provider number: 155173 AIM number: 100287760 Census Bed Type: SNF 12 SNF/NF: 58 Total: 70 Census Payor Type: Medicare: 11 Medicaid: 52 Other: 7 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 5, 2024.	F 0000	February 14, 2024 Indiana State Department of Health Division of Long-Term Care, Section 4 B 2 North Meridian Street Indianapolis, Indiana 46204 To Whom it May Concern: An Annual Survey was conducted at Miller's Merry Manor of Marion on January 30, 2024. Please find the enclosed Plan of Correction being submitted as remedies to the deficiencies that were found during our survey. All systemic changes and education will be completed by February 14, 2024. With regards to our Plan of Correction from the January 30, 2024 Annual Survey we hope that you will find our remedies both sufficient and thoroughly explained in providing a clear picture of how we corrected these concerns. We respectfully request *paper compliance* for this plan of correction for all three F Tags with a low level of scope and severity. All areas have been corrected, none of which were actual harm to any residents. We will continue to abide by our plan of correction as indicated, and will continue to monitor, through audits and correct any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	02/15/2024

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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			future areas of concern per our plan of correction. If you have any questions or require additional information, please contact me at 765 662 3981 Thank you. Sincerely, Paula Juday, HFA, LMSW	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to implement individualized interventions to prevent the worsening of a pressure injury. (Resident 63) Finding includes: During an observation, on 1/25/24 at 9:15 a.m., Resident 63 was sitting on the edge of his bed looking at items on his bedside table.	F 0686	**F 686 Treatment / Services to Prevent/Heal Pressure Ulcer** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to provide a comprehensive skin assessment upon admission	02/14/2024

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	During an observation, on 1/26/24 at 10:24 a.m., the resident was lying on his back in bed with his eyes closed. During an observation, on 1/26/23 at 4:08 p.m., the resident was sitting in his wheelchair in his room. During an observation, on 1/29/24 at 11:30 a.m., the resident was sitting on the edge of his bed feeding himself lunch. Resident 63's clinical record was reviewed on 1/26/24 at 3:36 p.m. His diagnoses included depression, generalized anxiety disorder, metabolic encephalopathy, combined systolic and diastolic congestive heart failure, end stage renal disease, dependence on renal dialysis, fracture of the neck of the left femur, and polyneuropathy. His current physician orders included protein supplement two times a day (dated 1/16/24) and wash left buttock, pat dry, apply liquid barrier film and collagen to wound bed, cover with a silver containing foam dressing, change every three days and as needed for soilage or dislodgement one time a day for wound care (dated 1/17/24). The order recapitulation lacked orders for treatment to the wound on the left buttock prior to 1/17/24. The admission Minimum Data Set (MDS) assessment, dated 1/15/23, indicated the resident was severely cognitively impaired. He required substantial/maximal assistance with lower body dressing and with moving from a sitting to a standing position. He required partial/moderate assistance to move from lying on the bed to sitting on the edge of the bed and to move from sitting on the edge of the bed to lying on the bed. He was frequently incontinent of bladder and		and at least weekly thereafter and to implement individual interventions according to the individual resident risk factors (Attachment 1-A) *Wound nurse educated regarding policy and procedure of Skin Management Program on 2/14/24. *Wound Nurse assessed resident 63 on 1/17/24 and weekly thereafter, reviewed orders, and reviewed care plan as appropriate for wound care. *Wound is healing and has measured smaller each week with current treatment in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility had the potential to be affected by the alleged deficient practice. *100% audit completed of all residents with wounds to ensure that all wounds are being assessed upon admission and at least weekly thereafter. No other residents were affected by this deficient practice. Completed 2/9/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**	

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	occasionally incontinent of bowels. He was at risk for developing a pressure injury. He had a stage 2 pressure injury on admission to the facility. He did not receive pressure injury care. He did not receive applications of ointments/medications other than to feet. A current wound care plan, initiated 1/9/24, indicated he was admitted with a wound that was potentially related to pressure, a pressure injury to left buttock. Risk factors included: debility, admitted with area, end stage renal disease requiring hemodialysis, congestive heart failure, history of smoking, coronary artery disease and low albumin. Interventions included administer protein supplement twice a day (1/25/24), administer treatment as ordered (1/9/24), assist with turning and repositioning as needed every two hours for pressure relief, and pressure relieving mattress. A current skin risk care plan, initiated 1/9/24, indicated the resident was at risk for skin breakdown. He had impaired mobility, frequent urine incontinence of small amounts, occasional bowel incontinence, history of smoking, end stage renal disease requiring hemodialysis, coronary artery disease, hypertension, and congestive heart failure. His interventions included assist to toilet &/or change frequently (1/25/24), monitor skin daily during care (1/9/24), provide a pressure reducing device to chair (1/25/24), provide a pressure reducing device to bed (1/9/24), and skin assessment at least weekly by the nurse (1/9/24). The nursing admission assessment, dated 1/8/24 at 11:37 p.m., indicated the resident admitted with a wound potentially related to pressure, described as two areas of excoriation to his left buttock. The measurement of the first area was 2 centimeters		*Wound nurse was educated regarding policy and procedure of Skin Management Program on 2/14/2024. *All nurse managers were educated regarding policy and procedure of Skin Management Program on 2/14/2024. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct Quality Assurance Audit using the QA Tool “Skin Management” (Attachment 1-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 10 weeks, and monthly X2. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool “Skin Management” By what date the system changes for the deficiency will be completed? 2/14/2024	

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	(cm) length (L) by 1 cm width (W). The measurement of the second area was 1 cm (L) by 0.3 cm (W). The assessment lacked a depth measurement of each area. A nursing assessment, dated 1/11/24 at 1:17 a.m., indicated the resident had a pressure related wound. A barrier cream was applied to the excoriation to the left buttock. A wound assessment, dated 1/17/24 at 1:54 p.m., indicated the resident had a pressure injury he was admitted with on his left buttock. The area was a stage 2 pressure injury with no change in status. The measurements of the pressure injury were 6.0 cm L by 2.5 cm W by greater than 0.1 cm depth. A progress note, dated 1/19/24 at 2:02 p.m., indicated an addendum to the admission assessment on 1/8/24. The report from the hospital indicated the resident had an abrasion to the left buttock. The facility admitting nurse evaluated the area as excoriation to the left buttock. The wound nurse evaluated the area to the left buttock as a stage 2 pressure injury. A wound assessment, dated 1/23/24 at 3:03 p.m., indicated the resident had a pressure injury he was admitted with on his left buttock. The area was a stage 2 pressure injury and was healing. The measurements of the pressure injury were 4.0 cm L by 2.5 cm W, with no depth. During wound observation, on 1/29/24 at 10:55 a.m., the resident's pressure injury on the left buttock/sacral area was the size of a quarter with less than 0.1 cm depth. At the same time, the Wound Nurse indicated the area had improved significantly.			

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	During an interview, on 1/29/24 at 11:45 a.m., the Wound Nurse indicated the resident was admitted with a wound to his buttocks. She was unable to locate orders for treatment to the pressure injury prior to 1/17/24 and indicated she would look into his record further. During an interview on 1/29/24 at 12:23 p.m., the Wound Nurse indicated the resident had received barrier cream to the pressure injury prior to 1/17/24, according to the several of the nursing assessments. Barrier cream did not require an order because it was a standard bedside cream. No treatment orders were initiated prior to 1/17/24. During an interview, on 1/30/24 at 2:45 p.m., CNA 6 indicated the resident could move around some on his own, but he had a lot of limitation because of his weakness. He rolled around in bed and often smeared bowel movement all over himself and the linens. Sometimes he had to be completely changed multiple times a shift because of his incontinence. At times, he would not permit the CNAs to change him. She applied barrier cream to his bottom like she did for all of her residents who were incontinent. During an interview, on 1/30/24 at 3:47 p.m., the ADON indicated the resident had a recent fracture and needed assistance with incontinence care and bed mobility. During an interview, on 1/30/24 at 3:51 p.m., CNA 7 indicated the resident was frequently incontinent. He required assistance to the bathroom and incontinence care. She put pillows on each side of him and assisted him to maneuver himself because his hip and bottom hurt.			

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	A current facility policy, dated 8/14/14, provided by the DON on 1/30/24 at 4:26 p.m., titled "Skin Management Program," indicated " ...It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers ...Interventions will be implemented according to the individual resident's risk factors that will best reduce the risk of development of pressure, diabetic ulcers, arterial or venous ulcers and/or promote the most effective healing of existing areas ...." 3.1-40(a)(2)			
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 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			

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	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 biologicals requiring refrigeration for Residents 55 and 122 were monitored per CDC guidelines for 2 of 2 refrigerators reviewed for medication/biological storage. Findings include: During an observation of the North 2 nursing unit medication storage room on 1/30/24 at 9:43 a.m., the medication refrigerator was locked. At the same time, the ADON indicated the medication room refrigerator temperature was checked daily and contained medications and vaccines. She did not have a key to the refrigerator. During an observation of the Boulevard nursing unit medication storage room on 1/30/24 at 9:53 a.m., the refrigerator contained a COVID 19 vaccine for Resident 55. At the same time, QMA 4 indicated she did not know what was usually kept in the refrigerator, as she did not pass insulin or typically have refrigerated medications she administered on the unit. The refrigerator temperature was checked daily by night shift. Review of a facility document, titled "Med Room Refrigerator Temperature Settings," provided by QMA 4 on 1/30/24 at 9:53 a.m., indicated the Boulevard Hall refrigerator had been checked daily. The log lacked a second temperature check for each day. During an observation of the North 2 nursing unit medication storage room on 1/30/24 at 1/30/24 at 10:41 a.m., the refrigerator contained an influenza	F 0761	**F 761 Label Store Drugs and Biologicals** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to store medications and biologicals following manufacturer's recommendations. (Attachment 2-A Storage of Medications) *The biologics for residents 55 and 122 were given per MD orders, residents were both monitored with no ill effects noted for either resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility had the potential to be affected by the alleged deficient practice. *100% audit completed of all residents with orders for vaccinations were reviewed with no other resident having vaccines stored in refrigerators at that time. No other residents were affected. Completed 2/9/24 **What measures will be put into**	02/09/2024

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	vaccine and a pneumococcal 20-valent conjugate vaccine for Resident 122. At the same time, the Wound Nurse indicated the refrigerator temperature was checked daily. Review of a facility document, titled "Med Room Refrigerator Temperature Settings," provided by the ADON on 1/30/24 at 10:42 a.m., indicated the North 2 Hall refrigerator had been checked daily. The log lacked a second temperature check for each day. During an interview on 1/30/24 at 12:50 p.m., the DON indicted the medication room refrigerator temperatures were checked daily, and vaccines were stored in them. During an interview on 1/30/24 at 4:41 p.m., the DON indicated the facility did not have a policy on the storage of vaccines. The article "Vaccine Storage and Handling Toolkit - January 2023," was retrieved on 1/31/24 from the Centers of Disease Control and Prevention website at https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. The guidance indicated if the temperature monitoring device did not read maximum/minimum temperatures then the temperature must be checked and recorded a minimum of two times a day as a minimal action to protect the vaccine supply. 3.1-25(m)		**place and what systemic changes will be made to ensure that the deficient practice does not recur** *Miller's Merry Manor changed our practice to reflect CDC guidance that the temperature must be checked and recorded a minimum of two times a day and implemented a new "Medication Room Refrigerator Freezer Temperature Form" (Attachment 2-B). 2/1/2024 *All Nursing staff were educated on the new practice and new log "Medication Room Refrigerator and Freezer Temperature Form" 2/1/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct Quality Assurance Audit using the QA Tool "Medication Storage" (Attachment 2-C). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 10 weeks, and monthly X2. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool "Medication Storage"	

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			By what date the system changes for the deficiency will be completed? 2/9/2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure staff followed physician orders for enhanced barrier	F 0880	**F 880 Infection Prevention & Control**	02/14/2024

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	precautions during an aerosol-generating procedure for 1 of 1 residents reviewed for respiratory care. (Resident 15) Finding includes: Resident 15's medical record was reviewed on 1/26/24 at 10:22 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia (an insufficient amount of oxygen), and generalized anxiety disorder. Her physician's orders included droplet isolation precautions during tracheostomy care, suctioning, and aerosol treatments (dated 4/20/22) and enhanced barrier precautions (EBP) during high contact resident care for her tracheostomy (dated 5/26/23). During an observation, on 1/25/24 at 3:15 p.m., a sign on the resident's door indicated enhanced barrier precautions were to be performed by anyone performing high-contact resident care activities. Instructions included performing hand hygiene and wearing gloves and a gown, when caring for or accessing the resident's tracheostomy. During the same observation, another sign indicated personal protective equipment (PPE) was required when an aerosol-generating procedure was in progress. The PPE required to enter the room included hand hygiene, an N95 mask, gown, gloves, and eyewear. During an observation, on 1/29/24 at 3:15 p.m., LPN 8 administered an aerosol treatment to the resident via her tracheostomy. The nurse did not perform hand hygiene or don PPE.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *It is the Policy of Miller's Merry Manor to follow standard precautions when administering Aerosol Generating Procedures. (Attachment 3-A) *Resident 15 was observed by nursing following administration of the aerosol treatment with no ill effects noted. *LPN 8 was educated on policy titled "Aerosol Generating Procedures". 1/30/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken** *All residents residing in facility receiving tracheostomy care had the potential to be affected by the alleged deficient practice. *100% audit completed of all residents with orders for tracheostomy care were reviewed with no other resident having tracheostomy at that time. No other residents were affected. Completed 1/30/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

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	During an interview, on 1/30/24 at 12:16 p.m., LPN 8 indicated she was unsure whether or not PPE was to be worn during the aerosol-generating procedure. She would have to ask if it was appropriate to perform the procedure without gloves and a gown. A current facility policy, titled "Aerosol Generating Procedures", dated 8/29/23, and provided by the Director of Nursing, on 1/30/24 at 4:54 p.m., indicated the following: "...perform nebulizer treatments with standard precautions (gloves, mask, and gown if performing the procedure). If setting up and assessing only, mask and gloves...." 3.1-18(a)		**practice does not recur** *All nursing staff were educated on the policy “Aerosol Generating Procedures” 2/14/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** *The facility will conduct Quality Assurance Audit using the QA Tool “EBP” (Attachment 3-B). This will be done 5X per week for 8 weeks, 3X per week for 8 weeks, weekly X 10 weeks, and monthly X2. This will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly. The facility will do so to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 60 days thereafter as part of the QA program using the QA Tool “EBP” By what date the system changes for the deficiency will be completed? 2/14/2024	