STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155574	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 14, 15, 16, 17, 18 & 21, 2022 Facility number: 000431 Provider number: 155574 AIM number: 100290380 Census Bed Type: SNF/NF: 27 SNF: 4 Total: 31 Census Payor Type: Medicare: 4 Medicaid: 23 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 12/1/22.	F 0000	Pleas accept the attached plan of correction as a credible allegation of compliance to the deficiencies cited curing our Annual Survey conducted on November 14-21, 2022. Hopefully you will find the remedies sufficient, thoroughly explained, and able to provide a clear picture of how we corrected the concerns. With this submission of these remedies, we are respectfully requesting paper compliance. If after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at 574-586-3133. Christy Clark, Administrator	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's			

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

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	needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in			

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	§413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on observation, record review and interview, the facility failed to ensure bowel incontinence was thoroughly assessed for 1 of 3 residents reviewed for incontinence. (Resident 24) Finding includes: Resident 24 was admitted to the facility with diagnoses including, but not limited to: Alzheimer's disease, aneurysm of the renal artery, ataxia, hypertension, psychosis, major depressive disorder, single episode, history of COVID -10, psychotic disorder with hallucinations, atrophy, dysphasia, unsteadiness on feet weakness, anxiety disorder, history of falling, anemia, hypercholesterolemia and GERD. The most recent Minimum Data Set (MDS) assessment, completed on 11/4/2022 indicated the resident was moderately cognitively impaired, required supervision and set up help for transfers and toileting needs, required limited staff assistance of one for hygiene needs and was frequently incontinent of her bowels and bladder The most recent bowel incontinence assessment, completed on 6/30/2022 indicated the resident was frequently incontinent of her bowels, was mentally and physically aware of the need to have	F 0636	It is the policy of Miller's Merry Manor Walkerton that the facility will assess Bowel/Bladder function with all admission, annual, and significant change comprehensive assessments. Resident #24 had new B/B assessment completed 12/13/2022. Resident showed no adverse effects to cited deficiency. Care plan was also updated accordingly. All residents have the potential to be affected. All resident's B/B assessments were reviewed and completed as needed to ensure timeliness and accuracy of assessments. Care plans were also reviewed/updated as needed. This was completed prior to 12/20/22. Staff inservice conducted to discuss B/B status of residents and changes to plans of care made prior to 12-20-22. CNA assignment sheets were updated with changes. A QAPI action plan has been initiated (Attachment D) The corrective action will be	12/20/2022

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	a bowel movement, had constipation issues but had did not have any toileting plan. The assessment indicated the resident transferred herself on and off the toilet, adjusted her clothing per self and needed staff assistance as needed for peri care and to ensure proper hygiene. The 6/29/2022 assessment did not indicate if any bowel patterning had been completed. The previously completed Quarterly MDS review, completed on 4/7/2022, indicated the resident was occasionally incontinent of her bowels. Resident 24 was observed, during the survey from 11/14/2022 through 11/18/2022 during the day, to spend large amounts of time, seated in her room in her wheelchair. She was not observed to be prompted or assisted by staff to utilize the toilet. She was observed, on 11/17/2022 at 11:24 A.M., propelling herself out of the restroom in her room. The licensed nurse passing medications in the hallway outside her room was unaware of where the resident was and did not realize she was in the bathroom, toileting herself. During an interview with CNA 7 , conducted on 11/18/2022 at 2:03 P.M., the resident was identified as usually continent of her bowel, capable of toileting herself and will notify staff if "she has an accident." The CNA indicated she did not usually prompt or routinely toilet Resident 24. During an interview with the Minimum Data Set (MDS) nurse, conducted on 11/21/22 at 10:35 A.M. she indicated she did not complete a bowel patterning for Resident 24 with her annual assessment. The MDS nurse confirmed she could not locate and herself had not completed any voiding patterning for bowel incontinence for Resident 24 in the past 12 months.		monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The MDS/Designee will complete the audit tool monthly x 6 months on all residents who received an admission, annual or significant change MDS .The QAPI action plan will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly until 100% compliance is met for three months consecutively.	

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	Review of the current Bladder and Bowel Rehabilitation Program policy, provided by the Assistant Director of Nursing on 11/18/2022 at 8:50 A.M. included the following procedures: "...Bowel Rehab Procedure: 1. Complete the bowel assessment form at admission, annually, and with significant changes...2. The 3-day bowel pattern is to be completed on all incontinent residents, upon admission and with significant changes to continent status to determine if any natural patterns can be determines...." 3.1-31(c)(4)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observations, record review and interviews, the facility failed to ensure care plans were complete for 2 residents in a sample of 12. (Resident 15 and 6) Findings include: 1. The clinical record for Resident 15 was reviewed on 11/16/22 at 11:06 A.M. Resident 15 was readmitted to the facility with diagnoses including, but not limited to: status post amputation right above the knee, type 2 diabetes mellitus, cardiac pacemaker, peripheral vascular disease, diastolic congestive heart failure, hypertension, chronic kidney stage 3,	F 0656	It is the policy of Miller's Merry Manor Walkerton that the facility will revise the resident's comprehensive plan of care with changes. Resident #6 Wrist support was added to HCP. Heel boots were added to plan of care. Resident had no adverse outcome. Resident #15 Care plan was updated to include medications. Resident had no negative outcomes. All residents have the potential to be affected. All resident care plans	12/20/2022

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	hypokalemia, aorocoronary bypass graff, urine retention, weakness, hx acute kidney failure, anxiety disorder, anemia and vitamin D deficiency. The current medication regimen included Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day for iron supplement and Ergocalciferol Capsule 1.25 MG (50000 UT)- Vitamin D, 1 capsule by mouth one time a day every 7 day(s) for supplement. The current care plans for Resident 15 did not include any plan to address the Ferrous Sulfate use or the Ergocalciferol (Vitamin D) use. During an interview with the MDS nurse on 11/21/2022 at 10:35 A.M. she indicated she did not necessarily care plan every supplement and confirmed a care plan had not been initiated for Ferrous Sulfate and/or Vitamin D use.2. A clinical review was completed on 11/16/2022 at 11:00 A.M., for resident 6, diagnoses included, but not limited to: chronic obstructive pulmonary disease, hemiplegia and hemiparesis cerebral infarction affecting the left non-dominant side, end stage renal disease, and anxiety disorder. During an observation on 11/14/2022 at 3:12 P.M., resident was wearing a left wrist support on. A Physician Order, dated 7/5/2022 indicated nursing to donn/doff left wrist support. Resident to wear during daytime/waking hours, off for hygiene or at residents request. Skin checks daily when donning/doffing at bedtime for wrist support. A Physician Order, dated 7/7/2022 indicated nursing to donn/doff left wrist support. Resident to wear during daytime/waking hours. Off for		have been reviewed and updated as needed. No negative resident outcomes have been noted. Staff inserviced regarding care plans/updated care sheets prior to 12-20-22. Facility to implement new clinical meeting in am after the morning department head meeting. Any new orders or changes in care will be discussed and reviewed and care plans/care sheets for CNAs updated at that time. Will continue current policy with routine care plan meetings and reviews. Resident health care plans to be updated daily M-F with changes. All HCP's will be reviewed quarterly at a minimum. A QAPI action plan has been initiated (Attachment E) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly until 100% compliance is maintained for three consecutive months.	

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	hygiene or at residents request. Skin checks with donning/doffing every day shift for wrist support apply upon waking. During an interview on 11/18/2022 at 8:38 A.M., MDS Nurse indicated she could not find a care plan for the wrist support and she should have had one. On 11/17/2022 at 9:30 A.M., the Assistant Director of Nursing provided a policy titled, "Care Plan Development and Review", dated 1/24/2020, and indicated the policy was the one currently used by the faciliity. The policy indicated "... To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment process.... " 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's			

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	representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to ensure a care plan was revised for 1 out of 13 residents reviewed for care plan revision. (Resident 6) Finding includes: A clinical record review was completed on 11/16/2022 at 11:00 A.M., for resident 6. Diagnoses included, but not limited to: chronic obstructive pulmonary disease, hemiplegia and hemiparesis cerebral infarction affecting the left non-dominant side, end stage renal disease, and anxiety disorder. A Physician Order, dated 12/6/2021, indicated heel protectant boots while in bed. During an interview on 11/16/2022 at 11:33 A.M., MDS Nurse indicated that she does not see the heel protectant boots on the care plan and they should have been care planned. On 11/21/2022 at 12:03 P.M., the ADON provided the policy titled, " Millers Health System, Inc. Policy Care Plan Development and Review", dated 11/21/2022 and indicated the policy was the one	F 0657	It is the policy of Miller's Merry Manor Walkerton that the facility will revise the resident's comprehensive plan of care with changes. Resident #6 Wrist support was added to HCP. Heel boots were added to plan of care. Resident had no adverse outcome. All residents utilizing assistive/preventive devices have the potential to be affected. All resident care plans have been reviewed and updated as needed. No negative resident outcomes have been noted. Staff inserviced regarding care plans/updated care sheets prior to 12-20-22. Facility to implement new clinical meeting in am after the morning department head meeting. Any new orders or changes in care will be discussed and reviewed and care plans/care sheets for CNAs updated at that time. A QAPI action plan has been	12/20/2022

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	currently used by the facility. The policy indicated"... It is the policy of Millers Merry Manor Overall review of the care plan is completed in conjunction with the MDS quarterly, annual and significant change assessments. and Care plans will be revised daily and PRN as changes in the resident conditions dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, ADL changes, skin changes ect...." 3.1-31(e)		initiated (Attachment F) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until facility has 100% times 3 consecutive months.	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview and record review the facility failed to ensure insulin is administered at an appropriate time after obtaining a blood sugar. Finding includes: During an observation on 11/18/2022 at 5:42 A.M., Registered Nurse (RN) 4 obtained a blood sugar for resident 1. On 11/18/2022 at 7:09 A.M., Licensed Practical Nurse (LPN) 6 administered Resident 1's morning insulin. During an interview on 11/18/2022 at 5:42 A.M., RN 4 indicated that the midnight shift obtains the	F 0658	It is the policy of Miller's Merry Manor Walkerton that services provided by the facility meet professional standards of care. No residents have experienced negative effects related to deficiency cited. All residents receiving glucose monitoring and insulin have the potential to be affected. Blood glucose monitoring time has been changed and insulin will be administered after that time. All nurses/QMAs have been educated on the change in glucose monitoring times and insulin admin. This was completed	12/20/2022

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	blood sugars and day shift gives the insulin after report. The standard of practice would be to do the blood sugar and then give the insulin. During an interview on 11/18/2022 at 7:07 A.M., LPN 6 indicated that midnight shift does all the blood sugars and day shift gives all the insulin between 6:45-7:00 A.M. During a review of the blood sugars under the vital sign tab indicated that on 11/3/2022 a blood sugar was taken at 4:56 A.M. and the medication administration audit report indicated he received his insulin at 6:52 A.M.; 11/6/2022 blood sugar at 5:15 A.M. and insulin given at 7:05 A.M.; 11/11/2022 blood sugar at 5:17 A.M. and insulin given at 7:01 A.M.; 11/12/22 blood sugar at 5:36 A.M. and insulin given at 8:48 A.M.; 11/13/2022 blood sugar at 5:03 A.M. and insulin at 6:56 A.M. and 11/18/2022 blood sugar at 5:44 A.M. and insulin given at 7:09 A.M., Physician Orders, indicated blood sugars were scheduled at 5:30 A.M. every day one times a day and insulin was scheduled twice a day at 7:30 A.M. and 2030. During an interview, on 11/18/2022 at 12:48 A.M., the Director of Nursing indicated that it is not the standard of practice to take a blood sugar and then administer insulin over an hour after it is taken. On 11/21/2022 at 12:35 P.M., the Assistant Director of Nursing provided a policy titled, "Injection - Subcutaneous Procedure", dated 3/21/2011, and indicated the policy was the one currently used by the facility. The policy indicated "...Ensure that the resident receives the med at the correct time - 60 min before or after		prior to 12-20-22. A QAPI action plan was initiated. (Attachment G) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until facility has 100% compliance times 3 consecutive months.	

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	scheduled time...." 3.1-35(g)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observations, interview and record review, the facility failed to ensure physician orders were followed for 1 of 1 resident reviewed for heel protectors. (Resident 6) Finding includes: A clinical review was completed on 11/16/2022 at 11:00 A.M., for resident 6, diagnoses included, but not limited to: chronic obstructive pulmonary disease, hemiplegia and hemiparesis cerebral infarction affecting the left non-dominant side, end stage renal disease, and anxiety disorder. During an observation on 11/14/2022 at 11:30 A.M., the resident was in bed sleeping there were 2 large green boots on the chair and no boots on her feet. On 11/16/2022 at 11:11 A.M., the resident was in bed and no boots on her feet they were sitting on the chair. A Physician Order, dated 12/6/2021 indicated heel	F 0684	It is the policy of Miller's Merry Manor Walkerton that quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Resident #6 experienced no adverse effects. All residents requiring preventive measures in place for care have the potential to be affected. Review was completed of residents to ensure that ordered preventive measures were in place and being provided as per the health care plan prior to 12/20/22. CNA care sheets reviewed and updated prior to 12/20/22. Staff inservice provided and discussed resident care needs/plans of care prior to 12-20-22. A QAPI action plan was initiated. (Attachment H) The corrective action will be	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155574	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

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	protectant boots while in bed every shift. During an interview on 11/16/2022 at 11:24 A.M., Registered Nurse 1 indicated she does not have heel protectors on and should have. On 11/16/2022 at 3 P.M., a policy was requested but one was not provided. 3.1-37		monitored using the QA Tool Annual Survey POC Audit Tool. (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until the facility has 100% compliance time 3 consecutive months.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services			

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	to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for incontinence had interventions to restore as much continence as was possible and prevent urinary tract infections. (Resident 18) Finding includes: Resident 18 was admitted with diagnoses including, but not limited to: dementia, hypothyroidism, osteoporosis, anxiety disorder, arteriosclerosis of native arteries of bilateral lower extremities, hypertension, hypercholesterolemia, history of COVID 19, Vitamin D deficiency, difficulty walking, Basal cell carcinoma of the skin on right upper limp, including shoulder, unsteadiness on feet, malaise and chronic kidney disease stage 3. Review of the most recent Quarterly MDS assessment, completed on 08/31/2022, indicated the resident was severely cognitively impaired, required supervision and set up only for toileting and limited assist of one staff for personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of their bowels. Review of the Annual MDS assessment,	F 0690	It is the policy of Miller's Merry Manor Walkerton that residents receive upon admission services and assistance to maintain continence. Resident #18 experienced no adverse effects. A new B/B assessment was completed and HCP updated. All residents requiring interventions to maintain/restore B/B function have the potential to be affected. Review was completed of residents to ensure that B/B assessments were accurate and the HCP reflects the resident's individual needs. CNA care sheets reviewed and updated prior to 12/20/22. Staff inservice provided and discussed resident care needs/plans of care prior to 12-20-22. A QAPI action plan was initiated. (Attachment I) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The DON/Designee will complete the	12/20/2022

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	completed 3/16/2022, indicated the resident was frequently incontinent of her bladder and always continent of her bowels. The most recent Bladder Incontinence Assessment, completed in March 11, 2022, indicated the resident was frequently incontinent of her bladder, was mentally aware of the need to void and included the following statement: "(Resident's name) is able to walk into the bathroom using her rollator, she can pull up and down her clothing and pull up and can it as needed. She is able to perform own peri care, staff monitors for proper hygiene" The form indicated the resident could sit on a toilet, was mentally aware of the need to void and could hold it if needed but "No" was marked for toileting program. The form indicated a voiding pattern was last assessed in 2017. The Bowel Continence Assessment, completed on 3/11/2022, indicated the resident was always continent of her bowels. The most recent care plan regarding incontinence, reviewed on 9/15/2022 as current, indicated the resident had frequent bladder incontinence and occasional bowel incontinence with the potential for skin breakdown related to a long history of incontinence. The goal for the plan for was the resident to remain clean, dry and odor free with no signs of skin breakdown from incontinence. The interventions included: Change pad as needed monitor for proper hygiene, pressure relief mattress on bed, remind to reposition self every 2 hours to prevent skin breakdown and weekly skin assessment. During an interview with CNA 7, conducted on 11/18/2022 at 2:04 P.M., she indicated Resident 18		audit tool daily M-F for 6 months .This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until facility has maintained 100% compliance for three consecutive months.	

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	toileted herself but the resident was getting more and more confused and thinks the resident "forgets" to go to the bathroom and is more incontinent. She indicated the resident was not routinely toileted and not routinely assisted in the bathroom. CNA 7 did indicate Resident 18 was needing more assistance lately with changing into her pajamas at bedtime. Resident 18 was observed during the survey, 11/14/2022 through 11/18/2022 during the day time to ambulate independently with her walker throughout the building. She often needed reminders and direction to get from her room to the dining room and activity room. She was also noted to lay horizontally across her bed with her back against pillow and the wall and nap during the day. She was not observed to be prompted or assisted to the bathroom by staff. During an interview with the MDS nurse, conducted on 11/21/22 at 10:44 A.M., she indicated there was no intervention to address any actual toileting need and was going to add an intervention. Review of the current facility policy and procedure, titled, "Bladder and Bowel Rehabilitation Program" provided by the Assistance Director of Nursing on 11/18/2022 at 8:50 A.M. indicated the purpose of the program was to "promote continence through means of bladder and/or bowel retraining or individualized habit programs based on the resident's cognitive ability or to keep the resident clean and dry and to enhance continence by providing routine or scheduled intervals of toielting assistance. The procedure portion of the policy included the following: "C. Bladder Habit Training Program			

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	(routine assisted or promoted toileting) 1. Determine if there is a pattern from the 3 day voiding assessment. 2. If there is a pattern, develop the toielting program from this pattern. 3. If there is not determinable pattern, develop a plan to toilet the resident at regular intervals and prevent incontinence related complications. 4. Update the care plan and CNA assignment sheet to include the plan...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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. Based on observation, interview and record review, the facility failed to ensure signage was posted on the resident doors that oxygen is in use, that continuous positive airway pressure (CPAP) and nebulizers were in a storage bag when not in use, and an open date was on gallon of water and CPAP Soclen and supplies were not stored on the floor. (Resident 4 & 14) Findings include: 1. A clinical review was completed, on 11/16/2022 at 10:15 A.M., for resident 4. Diagnoses included, but not limited to: chronic obstructive pulmonary disease, dysphagia, type 2 diabetes, heart failure,	F 0695	It is the policy of Miller's Merry Manor Walkerton that the resident's needs for respiratory care will meet professional standards of practice. Resident #4 All deficiencies noted have been resolved. Resident had no adverse outcomes. Resident #14 All deficiencies noted have been resolved. Resident had no adverse outcomes. All residents with specialized respiratory needs have the potential to be affected. These	12/20/2022

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	and sleep apnea. During an observation, on 11/14/2022 at 2:47 A.M., there was CPAP tubing and storage bag undated, no open date on a half gallon of water and full gallon sitting on the floor, and no signage indicating oxygen was in use. On 11/15/2022 at 9:15 A.M., there was CPAP tubing and storage bag undated, CPAP mask sitting outside of storage bag, no open date on a half-gallon of water and full one sitting on the floor, and no signage indicating oxygen was in use. On 11/16/2022 at 10:30 A.M., there was CPAP tubing not in the bag sitting on the end of the resident's bed, tubing and storage bag undated, no open date on half-gallon of water and full one sitting on the floor. During an interview, on 11/16/2022 at 10:40 A.M., Registered Nurse 1 indicated he does not have a sign on the door and should have a sign indicating oxygen is in use, the CPAP mask should not be on the bed but in the bag, and the bag the CPAP tubing does not have a date and it should, the bag should have a name, date and what is supposed to be in it. She indicated he has a stay clean machine on the floor that they use to clean his tubing, the machine should not be on the floor as well as the unopened gallon of water. The open gallon of water doesn't have an open date and should have. 2. A clinical record review was conducted on 11/16/2022 at 11:06 A.M., for resident 14. Diagnosis included, but not limited to: chronic obstructive pulmonary disease, chronic kidney disease, anxiety disorder, dementia with behavior		residents have been reviewed and any issues noted have been corrected. No negative resident outcomes have been noted. Staff inserviced regarding respiratory care including the use of oxygen signs for doors, storage of respiratory equipment and the labeling of supplies when opened prior to 12-20-22. A QAPI action plan has been initiated. (Attachment J) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until the facility has achieved 100% compliance for three consecutive months	

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	disturbances. During an observation on 11/14/2022 at 11:10 A.M., nebulizer tubing wasd sitting on top of the machine dated 11/7/2022 and not in a storage bag when not in use. On 11/15/2022 at 9:09 A.M., nebulizer tubing was sitting on top of the machine dated 11/7/2022 and not in a storage bag when not in use. During an interview on 11/16/2022 at 10:54 A.M., Registered Nurse 1 indicated the nebulizer was dated11/17/2022 and should have been changed on 11/14/2022 and the equipment should have been stored in a bag when not in use. On 11/17/2022 at 9:30 A.M., the Assistant Director of Nursing indicated that this the policy currently used by the facility, titled "High Mist Nebulizer or Oxygen Tank Procedure", 20. If desired, have the resident rinse mouth with tap water after using nebulizer. Place the nebulizer set into a plastic bag between uses. Do not rinse. Neb set is changed weekly per facility schedule. And a policy titled, "Oxygen Administration Protocol", 5. Administration: C. Place OXYGEN IN USE/NO SMOKING signs on the front and back of the resident's door. 7. Equipment Care A. Cannulas, masks and tubing should be changed weekly and change documented on the treatment record. Policy titled, "Delivery and Storage of Medical Equipment and Supplies", 1. Once delivered into the facility, medical equipment and supplies will be immediately placed in a secure location, if not placed at bedside for immediate use by the resident. 8. No products will be stored on the floor...." 3.1-47(a)(6)			

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F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but			

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	are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, record review and interview, the facility failed to ensure the physician responded timely to pharmacy recommendation for 1 of 5 residents reviewed for medication use. (Resident 15) Finding includes: The clinical record for Resident 15 was reviewed on 11/16/22 at 11:06 A.M. Resident 15 was admitted to the facility with diagnoses including, but not limited to: Status Post amputation right above the knee, Type 2 diabetes mellitus, Cardiac pacemaker, Peripheral Vascular Disease, Diastolic congestive heart failure, hypertension, chronic kidney stage 3, hypokalemia, angiocoronary bypass graff, urine retention, weakness, history of acute kidney failure, anxiety disorder, history of falls, major depressive disorder - single event, , fibromyalgia, heart aortic valve stenosis, hypothyroidism, atherosclerotic heart disease and stenosis of bilateral carotid arteries. A pharmacy recommendation form, dated 9/5/2022, requested the medication, Metoprolol Tartrate frequency or type of medication be changed. The space on the form for the physician to document a response and sign and date the form was left blank. Hand written, on bottom of form, not signed or dated was the following: "Not currently on this." Review of the electronic medication orders for Metoprolol Tartrate indicated it was not	F 0756	It is the policy of Miller's Merry Manor Walkerton that the physician will respond timely to pharmacy recommendations. Resident #15 The recommendation was completed 11-1-22. The resident experienced no negative outcome. All residents who receive physician recommendations have the potential to be affected. The last three months of physician recommendations have been reviewed to ensure all were addressed. No negative resident outcomes have were noted. Staff inserviced regarding physician recommendations and timeliness of response prior to 12-20-22. The clinical services consultant has worked with the DON to set up a system check to ensure that recommendations are addressed timely. Once the recommendation is addressed the DON/Designee will place in the clinical record. The DON will also keep a copy of all recommendations received and addressed. A QAPI action plan has been initiated. (Attachment K) The corrective action will be monitored using the QA Tool Annual Survey POC Audit	12/20/2022

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	discontinued until 11/01/2022. During an interview, conducted with the Director of Nursing, regarding the lack of a physician signature or date on the pharmacy recommendation form, she indicated she had just copied the form and the original form should be on the resident's "hard"chart. The Infection Prevention nurse, LPN reviewed Resident 15's hard chart and could not locate the signed and/or dated pharmacy recommendation form. The Director of Nursing provided a physician progress note, dated 11/01/2022, which indicated the the physician was notified of the pharmacy recommendations and an order, dated 11/01/2022 which indicated the Metoprolol was to be discontinued . Review of the facility policy and procedure, titled "Documentation and Communication of Consultant Pharmacist Recommendations" provided by the Assistant Director of Nursing on 11/18/2022 at 8:50 A.M., included the following: "...The timing of these recommendations should enable a response prior to the next medication regimen review..." A pharmacy medication review for Resident 15 was conducted on 9/5/2022, 10/4/2022 and 11/2/2022. 3.1-25(i)		Tool (Attachment C). The DON/Designee will complete the audit tool daily M-F for 6 months. This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until the facility has achieved 100% compliance for three consecutive months.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

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	the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure appropriate diagnosis for an antipsychotic medication for 1 out of 5 residents reviewed for unnecessary medication. (Resident 3) Finding includes: A clinical record review was completed on 11/17/2022 at 11:05 A.M., for resident 3, diagnoses included but not limited to: mild intellectual disabilities, post-traumatic stress disorder, chronic cerebral palsy, major depressive disorder, and cerebral infarction affecting left non-dominant side. A Physician Order, dated 9/16/2022 indicated abilify 2 milligrams (MG) take 1 tablet by mouth one time a day for intermittent explosive behavior. During an interview, on 11/17/2022 at 2:49 P.M., Social Service indicated that abilify is an antipsychotic and intermittent explosive behavior is not an appropriate diagnosis. On 11/17/2022 at 4:10 P.M., the Social Service provided a policy titled, "Psychotropic Drug Use Policy", dated 2/18/2019, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. The facility will assure that medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for psychotropic medication is obtained/received...." 3.1-48(a)(4)(b)(1)	F 0758	It is the policy of Miller's Merry Manor Walkerton that all psychotropic medications ordered will have approved and appropriate diagnosis for use. Resident #3 Physician was consulted and diagnosis has been updated. No negative outcome was noted. All residents who receive antipsychotic medications have the potential to be affected. A review has been completed of all residents receiving antipsychotic medications to ensure appropriate Dx is in place. No negative resident outcomes identified. Staff inserviced regarding need for appropriate dx for administration of antipsychotic medication prior to 12-20-22. The facility will continue the monthly behavior meetings to review/discuss all psychoactive medications. They will review and ensure appropriate diagnoses are in place for those receiving medications. A QAPI action plan has been initiated. (Attachment L) The corrective action will be monitored using the QA Tool Annual Survey POC Audit Tool (Attachment C). The SS/Designee will complete the audit tool on 25% of resident population monthly for 6 months.	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155574	A. BUILDING 00 B. WING	11/21/2022

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			This will be followed, reviewed and updated as needed in the facility Quality Improvement meeting monthly. The plan will continue until the faciity has achieved 100% compliance for three consecutive months.	
F 0865 SS=E Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at			

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	each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:			

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	§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to ensure Quality Assurance and	F 0865	It is the policy of Miller's Merry Manor Walkerton that the facility	12/20/2022

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	Performance Improvement Plan (QAPI) was carried out per their policy. Finding includes: On 11/21/2022 at 10:30 A.M., during the review of the QAPI facility task the Administrator indicated she had not done QAPI since the pandemic, she thought it was on hold. She recently started it back up on 10/25/2022. She should have been conducting QAIP meeting; their policy is monthly. The Infection Preventionist did the nursing part, but they did not meet as a group. During an interview, on 11/21/2022 at 10:50 A.M., the Infection Preventionist indicated she went over the monthly infection control with the Director of Nursing and provided a report to the medical director and the nurse practitioner but did not meet in a group setting such as QAPI. No past noncompliance provided. On 11/21/2022 at 10:40 A.M., the Administrator provided a policy titled, "Quality Assurance and Performance Improvement Plan and Program", dated 11/8/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... Element 2: Governance and Leadership 1. The Administrator will be the owner of the QAPI process oversight. 2. The steering committee of the QAPI program will be the members of the exiting QAA committee including the Medical Director, Administrator, Director of Nurses, Infection Prevention Nurse and will include a member of the Miller's Health System Executive Committee when available. 3. The QAPI Steering committee will meet no less than monthly. More meetings may be conducted as needed...."		will develop, implement and maintain an effective, comprehensive, date driven QAPI program that focuses on indicators of the outcomes of care and quality of life per facility policy. All residents have the potential to be affected by this deficient practice. The QAPI program has been restarted and the team is meeting on a routine monthly basis. This started in October 2022. Education was provided to the QAPI committee on 10/25/22 per the nurse consultant for the facility. The committee met on November 28 and another meeting is set for December 29. A QAPI action plan was initiated to follow this issue (Attachment M). To ensure ongoing compliance the ADM/Designee will complete the audit tool titled Annual Survey POC Audit Tool monthly (Attachment C) until 100% compliance is maintained for six consecutive months. The QAPI action plan will be reviewed and revised as needed in the monthly QAPI meeting.	

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F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and			

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	information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.			

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	§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen			

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	reviews, and act on available data to make improvements. Based on interview and record review, the facility failed to ensure Quality Assurance and Performance Improvement Plan (QAPI) was carried out per their policy. Finding includes: On 11/21/2022 at 10:30 A.M., during the review of the QAPI facility task the Administrator indicated she had not done QAPI since the pandemic, she thought it was on hold. She recently started it back up on 10/25/2022. She indicated she should have been conducting QAIP meeting; their policy is monthly. The Infection Preventionist did the nursing part, but they did not meet as a group. Reviewed the Action Plans from the 10/25/2022 meeting: 1. Problem/Concern: Not having routine QAPI meetings or following policy for QAPI implementation. Goal: Will follow company policy and meet monthly. 2. Falls - QM's 99.9%, falls lacking timely IDT F/U at times and appropriate intv. 3. empty food temp logs 4. 22.5% of residents using antipsychotic meds. Threshold =15%, 5. Kitchen ansul system need hydro test. On 11/21/2022 at 10:40 A.M., the Administrator provided a policy titled, "Quality Assurance and Performance Improvement Plan and Program", dated 8/11/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... Element 4: Performance Improvement Projects: 1. PIP is based upon the problem identified as needing improvement and based upon "high risk, high volume, problem prone" areas related to quality of care, quality of life or resident choice. Element 5: Systemic Analysis and Systemic Action: 1. Our facility	F 0867	It is the policy of Miller's Merry Manor Walkerton that the QAPI committee will develop and implement appropriate action plans to correct identified deficiencies. All residents have the potential to be affected. New action plans have been initiated for all the deficiencies cited in the annual survey. These will be followed by the QAPI committee in the monthly QAPI meeting for a minimum of six months. The committee will determine when the issue is resolved. Follow up review of the action plan will be determined at that time by the committee. A QAPI action plan has been initiated to follow this issue (Attachment M). To ensure ongoing compliance the ADM/Designee will complete the audit tool titled Annual Survey POC Audit Tool (Attachment C) monthly until 100% compliance is maintained for six consecutive months. The QAPI action plan will be reviewed and revised as needed in the monthly QAPI meeting.	12/20/2022

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	analyzes problems based upon the data and uses root cause analysis (such as using the 5 Why method) to determine systemic changes and/or interventions to implement to achieve and sustain improvement...." 3.1-52			
F 0868 SS=D Bldg. 00	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.			

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	§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. Based on interview and record review, the facility failed to ensure Quality Assurance and Performance Improvement Plan (QAPI) was carried out per their policy. Finding includes: On 11/21/2022 at 10:30 A.M., during the review of the QAPI facility task the Administrator indicated she had not done QAPI since the pandemic, she thought it was on hold. She recently started it back up on 10/25/2022. She indicated she should have been conducting QAIP meeting; their policy is monthly. The Infection Preventionist did the nursing part, but they did not meet as a group. During an interview, on 11/21/2022 at 10:50 A.M., the Infection Preventionist indicated she went over the monthly infection control with the Director of Nursing and provided a report to the Medical Director and the Nurse Practitioner but did not meet in a group setting such as QAPI. On 11/21/2022 at 10:40 A.M., the Administrator provided a policy titled, "Quality Assurance and Performance Improvement Plan and Program", dated 11/8/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... Element 2: Governance and Leadership 1. The Administrator will be the owner	F 0868	It is the policy of Miller's Merry Manor Walkerton that the facility will develop, implement and maintain an effective, comprehensive, date driven QAPI program that focuses on indicators of the outcomes of care and quality of life per facility policy. This program is conducted by the QAAA/QAPI committee. The committee consists of all facility department managers, the medical director and the facility IP nurse. All residents have the potential to be affected by this deficient practice. The QAPI program has been restarted and the team is meeting on a routine monthly basis. This started in October 2022. Education was provided to the QAPI committee on 10/25/22 per the nurse consultant for the facility. The committee met on November 28 and another meeting is set for December 29. A QAPI action plan was initiated to follow this issue (Attachment M). To ensure ongoing compliance the ADM/Designee will complete the	12/20/2022

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	of the QAPI process oversight. 2. The steering committee of the QAPI program will be the members of the exiting QAA committee including the Medical Director, Administrator, Director of Nurses, Infection Prevention Nurse and will include a member of the Miller's Health System Executive Committee when available. 3. The QAPI Steering committee will meet no less than monthly. More meetings may be conducted as needed...." 3.1-52(a)		audit tool titled Annual Survey POC Audit Tool (Attachment A) monthly until 100% compliance is maintained for six consecutive months. The QAPI action plan will be reviewed and revised as needed in the monthly QAPI meeting.	
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,			

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	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 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.			

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	§483.80(f) Annual review. 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 ensure gloves were worn during administration of subcutaneous injection of insulin and glucometer was disinfected after use for 1 of 1 resident reviewed for medication administration, Findings include: On 11/16/2022 at 7:02 P.M., observed Licensed Practical Nurse (LPN) 2 obtain a blood sugar. She placed the glucometer in a basket on top of alcohol preps, lancets and bottle of strips and went to the room. She donned gloves. After she took the blood sugar she placed the meter back in the basket on top of the supplies and placed the used lancet in a medication cup sitting it in the basket. During an interview, on 11/17/2022 at 7:08 P.M., LPN 2 indicated she did not wash her hands prior to donning the gloves and that she should not have placed the glucometer in the basket with the clean supplies without disinfecting it. On 11/16/2022 at 7:14 P.M., observed LPN 2 administer insulin: she entered the room, asked the resident where she would like it, she wiped the area with an alcohol prep, injected the med, placed same alcohol prep over the site and held for several seconds after disposal of syringe she used Alochol based hand rub (ABHR). During an interview, on 11/16/2022 at 7:16 P.M., LPN 2 indicated she did not wash her hands prior to the administration of the insulin and she was	F 0880	It is the policy of Miller's Merry Manor, Walkerton to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. No residents had negative outcomes related to this concern. All Residents have the potential to be affected by lack of compliance following infection control prevention measures. No negative outcomes have been identified. InService provided to licensed staff and QMA's regarding infection control with med pass with return demonstration. Hand hygiene including handwashing and use ABHR with return demonstration was also completed prior to 12-20-22 with all nursing staff. Glucometer use/cleaning was completed with all licensed nurses and QMA's. Return demonstration was completed to ensure competency. Routine daily rounds on all shifts will be implemented to ensure infection control measures in place and followed accordingly by staff. Rounds will include med pass observation, glucometer use; HH observations will be a minimum of 30/month.	12/20/2022

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	155574	A. BUILDING 00 B. WING	11/21/2022

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	never taught to wear gloves when administering an injection. On 11/18/2022 at 12:30 P.M., the Administrator provided a policy titled, "Cleaning Of Glucometer", dated 4/23/2013, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. PURPOSE: To maintain infection control between resident use. 2. PROCEDURE: A. The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe (Clorox, Lysol, Gulf South etc) and completely wiping down the glucometer so it is visibly wet. Avoid getting the screen wet, as the disinfectant could leak into internal components and destroy the meter...." On 11/21/2022 at 9:00 A.M., the Administrator provided a policy titled, " Injection - Subcutaneous Procedure", dated 3/21/2011, and indicated the policy was the one currently used by the facility. The policy indicated "... 21. Perform hand hygiene and put on gloves...." 3.1-18(a)		QAPI Action Plan has been initiated (Attachment N) Quality Assurance tool: QA audit tool Annual Survey POC Audit Tool (Attachment C) will be completed daily (rotating shifts) for 6 weeks, weekly x for 6 weeks and monthly thereafter by the DON/Designee. Any issues/concerns will be addressed immediately. The corrective actions will be monitored through the facility QAPI program. The QAPI Action Plan will be reviewed/revised as needed in the monthly QAPI meeting. This plan will remain in place until 100% compliance is maintained for 6 consecutive months.	
F 0888 SS=D Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of			

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	all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination			

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	must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as			

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	defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on record review and interview, the facility	F 0888	It is the policy of Miller's Merry	12/20/2022

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	failed to ensure all staff were fully vaccinated for COVID 19 except for those staff having a granted exemptions. This deficient practice included 1 of 42 employees. (Employee 9) Finding includes: Review of the COVID-19 Staff Vaccination Status records for the facility's staff, provided on 11/14/2022 indicated of the facility's 42 employees, 31 were fully vaccinated, 10 had granted religious exemptions and one staff member was only partially vaccinated. The facility staff COVID 19 vaccination rate was 97.6% instead of the required 100 % Employee 9, a dietary employee had only received one of the two required Moderna brand COVID 19 vaccinations. The documentation provided indicated Employee 9 had received the vaccination on 8/15/2022. During an interview with the Quality Assurance Corporate nurse, conducted on 11/15/2022 at 10:40 A.M., it was confirmed that Employee 9 was only partially vaccinated, was not in the process of applying for any exemptions, had no reason to delay her second COVID 19 vaccine and had worked the previous day, 11/14/2022. During an interview with the Assistance Director of Nursing (ADON), the administrative staff member responsible for tracking resident and staff COVID 19 vaccination status, conducted on 11/18/2022 at 10:30 A.M. she indicated she was aware Employee 9 was not fully vaccinated and "kept following up" (with employee 9) who told the ADON she was going to go get the second vaccination but did not comply.		Manor Walkerton that employees provide proof of vaccination for COVID according to the CDC or obtain an approved accommodation. One employee did not have a second dose in a two dose series within 8 weeks from t he date of hire. This employee received her second dose on 11/15/2022 (attachment P). All residents have the potential to be affected. To insure that this deficient practice does not occur in the future, all employees have been reviewed to ensure they are fully vaccinated or have an approved exemption on file. A QAPI Action Plan was initiated (Attachment O). The QA Tool titled Annual Survey POC Audit Tool (Attachment C) will be used to monitor all employee vaccines and that all first and second dose or accommodations are present. The Administrator/designee will be responsible for completing this tool. All employees that do not comply will be removed from the schedule. These reviews will be brought to the monthly QAPI meeting and will remain on the QAPI plan for a minimum of 6 months until 100% compliance is maintained. Any identified trends will be corrected upon discovery and documented and reported during the monthly QAPI meeting.	

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	Review of the facility policy and procedure, titled, Employee Vaccination Policy, provided by the Administrator on 11/18/2022 at 12:30 P.M., indicated the following was included: "...2. As a condition of employment each person beginning the hiring process shall receive the vaccinations required or obtain an approval accommodation in accordance with the following prior to providing any care, treatment or other services. ..6. Any employee who fails to comply with any of the provisions of this policy is will (sic) be removed from the schedule and subject to appropriate corrective action...."			