STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155578	A. BUILDING 00 B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	220 E DUNN RD NEW CARLISLE, IN 46552

(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 Complaint IN00407904. This visit resulted in an Extended Survey- Substandard Quality of Care- Immediate Jeopardy. Complaint IN00407904 - No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 27, 28 and 31, 2023. Facility number: 000527 Provider number: 155578 AIM number: 100267110 Census Bed Type: SNF/NF: 38 Total: 38 Census Payor Type: Medicare: 2 Medicaid: 31 Other: 5 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/8/2023.	F 0000	Please consider accepting our plan of correction. We believe this information provides a core component of education and provides for effective monitoring to ensure correction and ongoing compliance. Facility is requesting a face to face IDR for F-689.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

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

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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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review and interview, the facility failed to ensure the physician was notified timely of significant changes in condition for 3 of 13 residents reviewed. (Residents 2, 5 and 38) Findings include: 1. The clinical record for Resident 38 was reviewed on 7/25/2023 at 2:19 P.M. Resident 38 was admitted to the facility with diagnoses including, but not limited to: osteomyelitis of the vertebra, sacral and sacrococcygeal region, gout, idiopathic peripheral autonomic neuropathy, stage 4 pressure ulcer of the sacral region, chronic kidney disease stage 3B, glaucoma, age related osteoporosis, hypothyroidism, hypertension, cognitive communication deficit, hypokalemia, hyperlipidemia and abnormality of albumin. The Admission MDS (Minimum Data Set) assessment, completed on 6/13/2023, indicated the resident was mildly cognitively impaired, had little pleasure, felt down, had little energy, trouble sleeping and poor appetite for the past 7 - 13 days. It was somewhat important to her to have snacks in between meals, had not transferred out of bed for the assessment period, was totally dependent on staff for dressing, bed mobility, toileting, personal hygiene and bathing needs and required limited assistance from one staff for eating needs. The assessment indicated the resident had exhibited no swallowing or chewing issues, weighed 200 pounds and had not experienced any recent weight changes. The	F 0580	It is the policy of Miller's Merry Manor, New Carlisle, to immediately inform the resident, notify the physician, and resident representative of significant changes. Physician has been notified of Resident 2's blood sugars outside of parameters for the past 3 months, Resident 5's cord wrapped around neck on 6-6-2023, and Resident 38's weight loss earlier in July and present weight status. All residents have the potential to be affected by the alleged deficient practice. An audit completed by Clinical Service Nurse Consultant found no other residents affected. Nurses are expected to notify Physician per orders and for all change of condition requiring physician update and will be reviewed in the daily clinical meeting to ensure completion. On August 22, 2023 all licensed nurses including regularly scheduled contracted agency staff were trained on "Physician and Family Notification of Condition Changes" policy. QAPI audit tool titled, "2023 Survey Audit Tool" (Attachment A) will be completed weekly x 8 weeks, monthly x 4 months. Any	08/27/2023

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	resident was admitted with 1 stage 4 pressure ulcer. The current Care Plan related to nutritional needs, initiated on 6/6/2023, included an intervention to notify the physician and resident representative of significant weight loss. The Nutritional Assessment, completed by the RD (Registered Dietician) on 6/15/2023, indicated the resident had above normal BMI (Body Mass Index), had no weight trend identified yet, was on a NAS (No Added Sugar) diet with double eggs, vitamin and iron supplements and Proheal supplement. The weight record for Resident 38 indicated the following: On 6/6/2023 200 pounds. On 6/21/2023 179.4 pounds. On 7/5/2023 169.8 pounds. On 7/10/2023 154.6 pounds. On 7/12/2023 157.6 pounds. On 7/17/2023 154.9 pounds. On 7/24/2023 149.1 pounds. A Weight and Wound Meeting Progress Notes indicated a meeting had been held on 7/5/2023. The note acknowledged the weights on specific dates, indicated the resident had been admitted with edema, had an urinary tract infection and restated the resident's diet orders and supplements, which were put in place when she was admitted. The note did not indicated the percent of weight loss the resident had experienced since her admission, one month prior. The resident had lost 30.2 pounds, equivalent to 8.49 percent, denoting a significant weight loss. There was no documentation the physician was		issues will be corrected immediately. Findings will be reviewed through the QAPI committee and after 6 months a determination will be made to continue, change the frequency of or discontinue the audits.	

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	notified of the significant weight loss for Resident 38. A Weight and Wound Meeting Progress Note, completed on 7/13/2023, indicated a meeting had been held on 7/12/2023. The note documented the dates and weights of the resident since admission. The July 10 weight was 154.6 pounds, a weight loss of another 15.2 pounds since the 7/5/2023 meeting was held. The percent of weight loss since admission was now 23 percent. The note indicated a 4 ounce health shake at lunch was added to her diet, but there was no documentation the physician was notified of the significant, continued weight loss. There was no documentation of Physician notification of the significant weight loss until a late entry dated 7/20/2023 indicated the MD was notified of the continued weight loss and the daughter was being asked to set up a care plan meeting. During an interview with the Registered Dietician (RD), conducted 7/27/2023 at 10:00 A.M., she indicated the RD responsible for the facility was on vacation. She indicated there were interventions implemented on admission to address the resident's nutritional needs, the resident's diet was changed from no added sugar to regular on 7/5/2023 to allow more alternative choices and calories. Health shakes were added on 7/13/2023. The RD indicated the Wound and Weight Progress Notes could have been more specific regarding the percent of weight loss and should have reflected any Physician notification and interventions. During an interview with the Regional Nurse Consultant, on 7/28/2023 at 10:39 A.M., she			

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	indicated the physician would have documented weight loss notification but there was no documentation of the significant weight loss until 7/20/2023. 2. A record review for Resident 5 was completed on 7/26/2023 at 9:02 A.M. Diagnoses included, but were not limited to: Friedreich's Ataxia (disease which causes progressive nervous system damage), anxiety disorder, psychotic disorder with delusions due to known physiological condition, major depressive disorder, single episode, moderate, rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement and paraplegia unspecified. A Progress Note, dated 6/6/2023 at 4:24 P.M., indicated "...CNA came by nurse's station stating that resident had attempted to strangle himself with his bed cord. CNA went and got Social Services. Nurse went in and spoke with resident. Resident was tearful. Nurse asked Resident if he was trying to harm himself and he became even more tearful while shaking his head yes. Social Worker came in to speak with Resident. A Care Plan, created 1/10/2016, revised on 1/18/2023 and 6/15/2023, indicated "... I have altered mood related to dx. [diagnosis] of anxiety as evidenced by yelling/screaming/cursing at staff, clenching my fist, repetitive yelling out for specific people and refuses to talk when it is not what I want to hear and I attempt to wrap call cord around my neck for staff attention. Resulting in use of anxiolytic medication. Interventions: Approach in call manner and provide comfort /assurance during times of illness. Encourage use of two staff to reposition when in bed to reduce random movements by [Resident 5], Zip tie call cord to half side rail on bed with enough length at end for him to have call cord to half rail on bed			

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	with enough lengths at end for him to have call cord in lap to prevent him from attempting to wrap call cord around his neck. Medication as ordered. Notify physician as needed...." During an interview, on 7/26/2023 at 4:10 P.M., the Director of Nursing indicated that there was no unplanned occurrence completed or any documentation in the progress notes that the physician or family were notified about Resident 5 placing a cord around his neck. During an interview, on 7/27/2023 at 1:31 P.M., the Medical Director indicated that she was not notified of the incident that occurred on 6/6/2023 involving the resident placing a cord around his neck. During an interview, on 7/27/2023 at 2:31 P.M., RN 5 indicated she did not notify the physician or family that the resident wrapped a cord around his neck. 3. A record review for resident 2 was completed on 07/27/23 at 11:48 A.M. Diagnoses included, but were not limited to: type 2 diabetes, end Stage Renal Disease, dependence on renal dialysis and atrial fibrillation. A Quarterly MDS (Minimum Data Set) assessment, dated 7/14/2023, indicated Resident 2 had moderately impaired cognition. Resident 2's medication regimen, included but was not limited to: Baqsimi (Glucagon) inhalation powder as needed, Humalog insulin 4 units with breakfast and lunch, Lantus insulin 12 units once daily and Lantus insulin 8 units at bedtime. A Physician's Order, dated 11/18/2022, indicated the resident was to receive Insulin Lispro Solution			

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	100 UNIT/ML (milliliter) inject 4 unit subcutaneously two times a day for diabetes mellitus. There were parameters to notify the MD (Medical Doctor) if the resident's blood sugar was less than 70 or greater than 400. In addition, there were instructions to follow the blood sugar flowchart if the resident exhibited signs and/or symptoms of low blood sugar. The instructions also indicated the event was to documented in the Nursing Progress Notes. A review of the current Care Plan regarding blood sugar levels, indicated the following: "...I have Diabetes and the potential for having hyper/hypoglycemia as seen by: Interventions included: no signs and symptoms of high or low blood sugar levels, blood sugar less than 70 or greater than 200 requires an assessment documented on the blood sugar tracking form. Follow specific physician orders if symptoms present, blood sugar less than 70- give 4 oz juice and retest in 15-20 minutes, communicate blood sugar readings to (physician's name), give medications as ordered, notify MD (Medical Doctor) of blood sugar readings outside the ordered parameters, monitor and document food and fluid intake on point of care. Offer replacements for food uneaten if resident eats less than 50%, monitor blood sugar as ordered, monitor labs as ordered, monitor meal intake, serve diet as ordered...." A review of the blood sugar log for Resident 2 indicated blood sugar readings were out of range on the following days: 5/7/23 blood sugar was 67. 5/11/23 blood sugar was 63. 5/23/23 blood sugar was 63. 5/27/23 blood sugar was 60. 6/5/23 blood sugar was 70.			

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	6/12/23 blood sugar was 69. 6/13/23 blood sugar was 64. 6/15/23 blood sugar was 68. 6/20/23 blood sugar was 60. 6/24/23 blood sugar was 69. A notification to the doctor was made on 6/13/2023 for a blood sugar of 64 and a notification was written on 7/3/2023 for a blood sugar of 59, indicating the resident had no signs and symptoms of low blood sugar and 4 Units of Humalog was held. These notifications were found in the paper chart, no other documentation was found in the electronic medical record. No other progress notes were found to indicate communication or notification of other blood sugar readings or interventions were provided to the Medical Doctor. During an interview, on 7/31/2023 at 11:10 A.M., RN 5 indicated the Physician had discontinued the resident's Lispro and the Lantus insulin did not have any documented notifications. Staff were to notify the doctor if the resident's blood sugar was less than 70 or above 200. RN 5 indicated Resident 2 had been having some blood sugars that were "all over the place". RN 5 looked in the chart and indicated the highest blood sugar reading was 300, and the lowest reading was 56. She indicated the doctor should have been notified if the resident's blood sugar was less than 70. RN 5 indicated the doctor was made aware of Resident 2's blood sugar readings via a facsimile and presented documentation of the communication, dated 7/3/2023. During an interview, on 7/31/2023 at 11:32 A.M., the DON (Director of Nursing) indicated if a resident had an abnormal blood sugar reading, the nursing staff would call the doctor and document			

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	the communication in the resident's progress notes. If a note was documented in the MAR (medication administration record), a note would then populate in the nursing progress notes. On 7/31/2023 at 11:40 A.M., a current policy was provided by the DON (Director of Nursing), titled "Physician and Family Notification of Condition Changes". The policy had a start date of 11/30/2016 with no revision date. The policy included the following: " ...the purpose is to keep physician and family appraised of all condition changes either by telephone or fax cover sheet. Telephone notification is required for all emergencies, all condition changes, critical laboratory results, abnormal radiology or diagnostic test that require immediate response. Notify the physician of any change in condition that may or may not warrant a change in treatment plan. Document the information reported to the physician in the nurse's notes. Be thorough and explicit. Document the response from the physician in the nurse's notes. If faxing, document information in black ink on a fax form which includes a confidentiality statement. Include all information required for physician to make decisions. If immediate physician response is required, do not fax. Thoroughly document information to be reported in the nurse's note. Be thorough and explicit, including that the physician was faxed, date and time. Document in nurse's note when the physician responds to the fax. Notify the resident and responsible party of any change in condition that may or may not warrant a change in treatment plan, including critical lab values, abnormal radiology or diagnostic testing results ...." 3.1-5(a)(2)(3)			

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F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications			

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	and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on observation, record review and interview, the facility failed to ensure a baseline care plan was completed and a summary was shared with the resident and/or her representative for 1 of 1 new residents reviewed for baseline care plans. (Resident 38) Finding includes: The clinical record for Resident 38 was reviewed on 7/25/2023 at 2:19 P.M. Resident 38 was admitted to the facility on 6/6/2023 with diagnoses included, but not limited to: osteomyelitis of the vertebra, sacral and sacrococcygeal region, gout, idiopathic peripheral autonomic neuropathy, stage 4 pressure ulcer of the sacral region, chronic kidney disease stage 3B, glaucoma, age related osteoporosis, hypothyroidism, hypertension, cognitive communication deficit, hypokalemia, hyperlipidemia and abnormality of albumin. The Admission MDS assessment, completed on 6/13/2023, indicated the resident was mildly cognitively impaired, had little pleasure, felt down, had little energy, trouble sleeping and poor appetite for the past 7 - 13 days. It was somewhat important to her to have snacks in between meals, had not transferred out of bed for the assessment period, was totally dependent on staff for dressing, bed mobility, toileting, personal hygiene and bathing needs and required limited assistance from one staff for eating needs. The assessment indicated the resident had exhibited no	F 0655	It is the policy of Miller's Merry Manor, New Carlisle, to develop a baseline care plan within 48 hours of admission and provide a copy of a summary of the baseline care plan. Resident #38's baseline care plan summary along with review of her comprehensive care plan was completed on 7-31-23 with resident's representatives. All admissions have the potential for this deficit practice. The Admission coordinator along with her back-up, will be responsible to schedule the initial health care plan conference within 7 days of admission. This conference will include the resident, resident representative, and interdisciplinary team. A summary of the baseline care plan will be reviewed, signed, and dated. A copy placed in the hard copy medical record To ensure continued compliance, audit tool entitled, "2023 Survey Audit Tool" (Attachment A) will be completed weekly x 8 weeks, monthly x 4 months. Any issues will be corrected immediately. Findings will be reviewed through the QAPI committee and after 6 months a determination will be	08/27/2023

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	swallowing or chewing issues, weighed 200 pounds and had not experienced any recent weight changes. The resident was admitted with 1 stage 4 pressure ulcer. During an interview with Resident 38's representative, conducted on 7/24/2023 at 2:09 P.M., she indicated she had not been given any care plan documentation, had not received any invitation to a care plan meeting, nor had she participated in any care plan meeting since the resident had been admitted to the facility on 6/6/2023. During an interview with the Social Service Director, on 7/26/2023 at 1:47 P.M., she indicated there had been no initial care plan meeting or baseline care plan meeting set up for Resident 38. She indicated the department managers had signed a form on 6/7/2023 for a "New Admission Management Introduction and Review" meeting but there had not been a care plan meeting conducted. The Admissions staff member was responsible for setting up the initial care plan meetings, but there had been a vacancy for that position and the care plan meetings for Resident 38 had been missed. The current facility policy, titled, "Care Plan Development and Review," provided by the Director of Nursing on 7/28/2023 at 9:00 A.M., included the following: "...2. CARE PLAN DEVELOPMENT: A. An interdisciplinary team, in conjunction with the resident, physician and representative will develop a comprehensive care plan for each resident...4. CARE PLAN CONFERENCE: A. Care plan conferences with all disciplines will be held with resident and representative, at their convenience within seven days of admission, 21 days of admission,		made to continue, change the frequency of or discontinue the audits.	

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	quarterly, and as needed...B. VII. If representative is not present for the seven day care conference, a call will be made to them by the care plan coordinator or director of nursing to discuss the care plan...5. COMMUNICATION TO STAFF, RESIDENTS AND RESPONSIBLE PARTY: ...C. Residents and their representative will be given a summary of their baseline care plan by a member of the care plan team via printing: "resident dashboard" for that resident. The resident and/or resident representative will sign and date a copy of the summary to be placed in the medical record as evidence it has been received by the resident or representative...."			
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 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			

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	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, record review and interviews, the facility failed to ensure a care plan meeting was conducted after an admission assessment was completed for 1 of 13 residents reviewed. (Resident 38) The facility also failed to ensure a care plan was revised and updated regarding safety measures for 1 of 3 residents reviewed for accidents. (Resident 5) Findings include: 1. The clinical record for Resident 38 was reviewed on 7/25/2023 at 2:19 P.M. Resident 38 was admitted to the facility on 6/6/2023 with diagnoses included, but not limited to: osteomyelitis of the vertebra, sacral and sacrococcygeal region, gout, idiopathic peripheral autonomic neuropathy, stage 4 pressure ulcer of the sacral region, chronic kidney disease stage 3B, glaucoma, age related osteoporosis, hypothyroidism, hypertension, cognitive communication deficit, hypokalemia, hyperlipidemia and abnormality of albumin. The Admission MDS Assessment, completed on 6/13/2023 indicated the resident was mildly cognitively impaired, had little pleasure, felt down, had little energy, trouble sleeping and poor appetite for the past 7 - 13 days. It it was somewhat important to her to have snacks inbetween meals, had not transferred out of bed for the assessment period, was totally dependent on staff for dressing, bed mobility, toileting, personal hygiene and bathing needs and required	F 0657	It is the policy of Miller's Merry Manor, New Carlisle, to develop the comprehensive care plan within 7 days after completion of the comprehensive assessment by the interdisciplinary team. The care plan will be reviewed and revised after each assessment completed. Health care plan conference will be scheduled and resident and representative invited per policy. Health care plan will be revised as needed based on resident's needs Resident 38's care conference was conducted on 7-31-2023 with resident representatives, and interdisciplinary team. Resident 5's health care plan was revised to remove the intervention of low bed remains as part of the safety measure initiated on 7-26-23. All residents have the potential to be affected by the deficit practice. Review of the Care Plan Development and Review policy was completed by the Clinical Services Nurse Consultant with the interdisciplinary team on 8/21/23. Initial Admission Care Conference will be scheduled by the Admission Coordinator or her back-up. Comprehensive Care Plan conferences will be	08/27/2023

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	limited assistance from one staff for eating needs. The assessment indicated the resident had exhibited no swallowing or chewing issues, weighed 200 pounds and had not experienced any recent weight changes. The resident was admitted with 1 stage 4 pressure ulcer. During an interview with Resident 38's representative, conducted on 7/24/2023 at 2:06 P.M., she indicated she had not yet been invited to a care plan meeting. There were no nursing notes or documentation in the clinical record regarding any scheduling of a care plan meeting. During an interview with the Social Service Director, on 7/26/2023 at 1:47 P.M., she indicated there had been no initial care plan meeting or baseline care plan meeting set up for Resident 38. She indicated the department managers had signed a form, on 6/7/2023, for a "New Admission Management Introduction and Review" meeting but there had not been a care plan meeting conducted. She indicated the Admissions staff member was responsible for setting up the initial care plan meetings but there had been a vacancy for that position and the care plan meetings for Resident 38 had been missed. The current facility policy, titled, "Care Plan Development and Review," provided by the Director of Nursing on 7/28/2023 at 9:00 A.M., included the following: "...2. CARE PLAN DEVELOPMENT: A. An interdisciplinary team, in conjunction with the resident, physician and representative will develop a comprehensive care plan for each resident...D. The resident's comprehensive care plan is developed within seven (7) days of the completion of the		scheduled by the Social Service Director within 7 days of completion of each assessment. MDS Coordinator will serve as back-up for scheduling. Healthcare plans will be revised as needed and reviewed during the daily clinical meeting to ensure accuracy. To ensure continued compliance, audit tool entitled, “2023 Survey Audit Tool” (Attachment A) will be completed weekly x 8 weeks, monthly x 4 months. Any issues will be corrected immediately. Findings will be reviewed through the QAPI committee and after 6 months a determination will be made to continue, change the frequency of or discontinue the audits.	

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	comprehensive assessment or within twenty-one (21) days after the resident's admission...4. CARE PLAN CONFERENCE: A. Care plan conferences with all disciplines will be held with resident and representative, at their convenience within seven days of admission, 21 days of admission, quarterly, and as needed...B. VII. If representative is not present for the seven day care conference, as call will be made to them by the care plan coordinator or director of nursing to discuss the care plan...5. COMMUNICATION TO STAFF, RESIDENTS AND RESPONSIBLE PARTY: ...C. Residents and their representative will be given a summary of their baseline care plan by a member of the care plan team via printing: "resident dashboard" for that resident. The resident and/or resident representative will sign and date a copy of the summary to be placed in the medical record as evidence it has been received by the resident or representative...." 2. A record review for Resident 5 was completed on 7/26/23 at 9:02 A.M. Diagnoses included, but were not limited to: Friedreich's Ataxia (disease which causes progressive nervous system damage), anxiety disorder, psychotic disorder with delusions due to know physiological condition, major depressive disorder, single episode, moderate, rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement and paraplegia unspecified. During an observation, on 7/26/2023 at 10:47 A.M., Resident 5's bed was in a high position from the floor. During an observation, on 7/27/2023 at 9:52 A.M., the resident's bed was not in the lowest position. During an observation, on 7/28/2023 at 9:53 A.M., the resident's bed was not in the lowest position.			

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A Care Plan, dated 12/10/2015, indicated "...Fall Risk characterized by risk factors: Use of narcotics, antidepressant, anti-anxiety, back pain, Dx [diagnosis] of Fredrechs [sic] Ataxia. Limitations to all extremities. When up in w/c [wheelchair] will take off arm rests and slide self down w/c. Resident chooses to not get out of bed for therapy to eval [evaluate] for w/c seating." Interventions, dated 6/30/2023, included bed in lowest position when receiving suppository for BM [bowel movement], bed in lowest position. On 7/14/2023, bolsters to mattress for tactile boundaries was added.

During an interview, on 7/28/2023 at 9:55 A.M., the Director of Nursing (DON) indicated that a low bed is when it is lowered as far as it will go down. The interventions that were put in place after his fall were to put the bed in low position when receiving a suppository for BM and bolsters to the mattress. The other intervention of bed in lowest position was put in by the floor nurse and the care plan should have been revised.

On 7/28/2023 at 12:37 P.M., the 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 facility. The policy indicated "...3. CARE PLAN REVISION: A. Care plans will be revised daily and PRN as changes in the resident's condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes etc... 4. CARE PLAN CONFERENCE: A. Care plans conferences with all disciplines will be held with resident and representative, at their convenience within seven days of admission, 21 days of admission,

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	quarterly, and as needed. B. The initial (7 day) care plan conference will be held within seven days of admission with the resident, representative, available department heads, and care plan coordinator (designee). The Admission Director will set the time and date of the 7-day care conference during the time of the admission process...." 3.1-35(2)(B)(e)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure environmental hazards were removed from the resident's room after a suicide attempt for 1 of 2 residents reviewed for accidents/hazards. (Resident 5) The immediate jeopardy began on June 6, 2023 when Resident 5 wrapped a bed remote cord around his neck and the facility failed to remove the hazard from his room. The administrator and regional nurse consultant were notified of the immediate jeopardy on July 26, 2023 at 4:50 P.M. The immediate jeopardy was removed on July 27, 2023, but noncompliance remained at the lower scope and severity level of no actual harm, with potential for more than minimal harm that is not	F 0689	It is the policy of Miller's Merry Manor, New Carlisle, to ensure all residents have an environment free of accidents and hazards. Resident 5's bed cord was fastened to bed siderail, other media cords/devices were secured, and bed placed in low position on 7/26/23. All residents have the potential to be affected by the alleged deficient practice. All staff including contracted agency staff were inserviced on the Suicide Precautions policy on July 26th and 27th. All new staff and new contracted agency staff	08/27/2023

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	immediate jeopardy. Finding includes: A record review for Resident 5 was completed on 7/26/2023 at 9:02 A.M. Diagnoses included, but were not limited to: Friedreich's Ataxia (disease which causes progressive nervous system damage), anxiety disorder, psychotic disorder with delusions due to known physiological condition, major depressive disorder, single episode, moderate, rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement and paraplegia unspecified. During an observation, on 7/26/2023 at 10:47 A.M., the resident's bed was in a high position from the floor. During an observation on 7/26/2023 at 3:34 P.M., the bed remote cord was not fastened to the bed rail with a zip tie, only the call light was. The resident had full access to the bed remote cord hanging from the assist/bed rail. The bed was also not in a low position, but up high. A Progress Note, dated 6/6/2023 at 4:24 P.M., indicated "...CNA came by nurse's station stating that resident had attempted to strangle himself with his bed cord. CNA went and got Social Services. Nurse went in and spoke with resident. Resident was tearful. Nurse asked Resident if he was trying to harm himself and he became even more tearful while shaking his head yes. Social Worker came in to speak with Resident. A Progress Note, dated 6/6/2023 at 5:13 P.M., indicated "...Late Entry: SS [Social Service] visited with [Resident 5] today due to reports of increased behaviors. [Resident 5] presented very		are being trained on this policy. Environmental rounds are completed weekly in resident rooms to ensure resident safety by the maintenance director using the TELS worksheet located on-line. Maintenance checks Resident 5's environment 5x weekly to ensure all safety measures remain in place. To ensure continued compliance in addition to the above action, the audit tool entitled, "Suicide Precautions and Safety Review" (Attachment B) will be completed weekly x 8 weeks, monthly x 4 months. Any issues will be corrected immediately. Findings will be reviewed through the QAPI committee and after 6 months a determination will be made to continue, change the frequency of or discontinue the audits. New Carlisle IDR F689- Free of Accidents/Supervision/Devices. SS=J because the facility did not remove an environmental hazard (Bed Control/cord) The facility feels not all of the objective, historical facts that were available at the time of the survey were considered in this decision. Resident #5 has history of assessed attention seeking behavior which resulted in his first care plan for attention seeking	

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	emotional and became tearful several times during conversation. SS talked with him about putting cord around his neck. He expressed he was not trying to kill self. he just needed help from staff and he was frustrated. SS explained to [Resident] that when he does things like that he runs the risk of being sent to inpatient psyche stay. He expressed he did not want he wants. SS discussed alternate ways to get staff assistance. SS allowed him time to express his feelings and offered comfort and reassurance. SS offered him time to reminisce about when he was younger and mutual friends he has with SS. At the end of conversation he expressed he was doing better. he was no longer tearful and was smiling and laughing at times. SS will update psyche services and have them visit with him on next visit to the facility...." A Progress Note, dated 6/7/2023 at 2:22 P.M., indicated the resident was sent to the hospital to be evaluated for right lower quadrant pain. A Psychiatry Progress Note, dated 6/8/2023 from 7:30 A.M. to 7:55 A.M., indicated "....Symptom Description and Subjective Report; Patient is seen today for follow up assessment of mood and behavior and medications. Patient has been more irritable and made a gesture to harm himself...Objective Content: Alert and pleasant. Appears in no distress or discomfort. Resting in his bed. Engages in conversation easily. Able to make some needs known. Staff also will anticipate his needs. He had been more irritable and staff states he put the call light cord around his neck. Patient readily admits to doing so but states he was frustrated. He denies current suicidal ideations or intent to harm himself. Patient state he was in pain and "didn't feel well. He was recently seen in ER [Emergency Room] and		behavior in 2016, just after admission. The facility requests that the citation be removed or reduced in scope and severity based on the following: Resident #5 admitted to New Carlisle on 12/9/2015. Soon after admission he began to display behaviors that have been documented. He was attention seeking, not suicidal. 1/6/2016- Resident #5 was informed that therapy would be ending and that he would need 24-hourcare moving forward. Resident became angry. He began to yell and demanded his Dad be called. He also threatened to “throw himself out of bed.” Resident #5 did calm down after staff intervened. 1/19/2016-Staff was trying to transfer Resident #5 to a wheelchair from his bed. He demanded a different lift sling. When this didn’t happen quick enough, he then stated he would “put himself on the floor.” Resident later calmed down with staff intervention. 1/21/2016- Resident #5 was given an NPO order for an appointment from the Doctor. Resident demanded something to drink and staff tried to educate him on the importance of following Doctor’s orders. He became very angry with staff, undid his Velcro seatbelt and flopped forward in his wheelchair. The nurse caught	

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	diagnoses with a UTI [Urinary Tract Infection]. He is receiving[sic] an antibiotic. Staff also report he didn't have his scheduled pain medication due to an "insurance issue". Plan: Patient diagnosed with UTI and was not receiving his usual pain medication which likely contributed to his mood issues...." A Licensed Clinical Psychologist Progress Note, dated 6/8/2023 from 11:22 A.M. to 11:47 A.M., indicated "Patient was seen in follow-up for symptoms of depression and anxiety. Staff report that patient has been wrapping his call light around in neck in a gesture to hurt himself. Patient has a UTI, and has had increased pain because insurance issues have limited the pain medications that can be used. Staff are working to resolve this issue. Patient presents as very angry, tearful and expressed a desire to end his life. He calmed down and became more rational as we talked, and more calm at the end of the session. Staff were consulted about patient's labile mood, and about ways to manage his impulsive behavior...Objective Content: Patient and I talked about the fact that he was sent to the ER a couple of days ago because of pain and a UTI and they were not helpful. At first, patient was unable to think rationally about the fact that staff are working to manage his pain, and having a UTI will contribute to him feeling bad in general. He was able to calm down, and acknowledge he is more depressed but not planning to kill himself. Upon consultation, staff indicated they plan to lower patient's bed to the floor so he cannot injure himself by throwing himself out of bed, and securing his call light and bed control so he cannot hurt himself with the cords, in case he becomes upset again and tries to get impulsively...."		him. Resident later calmed down. 3/9/2016- Resident #5 was found with his call light cord wrapped around his neck. The staff removed the hazard and notified the Nurse. The Administrator, Doctor, and family were made aware of the situation. Suicide precautions were initiated. The resident was placed on 15-minute checks and all items within reach that posed a threat were removed. The Doctor and Hospice provider met bedside with the resident the same day. Resident #5 then told the Doctor he did this because he was in pain and needed more medication. He later told Social Services he had no plan to do so and did not intend to kill himself, he simply wanted medication. Thus, as early as March 2016, the staff was aware of and addressing this resident's self-proclaimed behavior seeking. This same date Resident #5 requested and refused his meds 7-8 times and threatened to "throw himself on the floor". Again, when Resident #5 didn't get what he wanted immediately, he acted out for attention. 3/19/2017- Two aides went in to assist Resident #5. He told them they didn't know what they were doing and to get the "f**k" out of his room. The nurse overheard the conversation and tried to approach the resident after the aides left. He told her the same thing and	

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	A Progress Note, dated 6/8/2023 at 1:20 P.M., indicated Resident 5 arrived back to the facility with antibiotics for the treatment of a urinary tract infection. A Care Plan, dated 6/15/2023, indicated "...I display irrational thoughts and ideas related to dx [diagnosis] of psychosis r/t [related to] Fredericks [sic] Ataxia as evidenced by digging in my ears thinking my hearing aides are wedged in my ears, thinking someone is remotely messing with my computer and convinced I can have an apartment and take care of self. Leading to potential for self-harm. Resulting in use of antipsychotic medication. Interventions: Allow [Resident 5] to express his thoughts and feelings and assist in helping him understand the reality of situations. Maintain a calm, consistent environment and attend to his basic needs. Provide support with skills to de-escalate, cope and manage stress. Make sure environment is clear of clutter or self-harm objects. A Care Plan, created 1/10/2016, revised on 1/18/2023 and 6/15/2023, indicated "... I have altered mood related to dx of anxiety as evidenced by yelling/screaming/cursing at staff, clenching my fist, repetitive yelling out for specific people and refuses to talk when it is not what I want to hear and I attempt to wrap call cord around my neck for staff attention. Resulting in use of anxiolytic medication. Interventions: Approach in call manner and provide comfort /assurance during times of illness. Encourage use of two staff to reposition when in bed to reduce random movements by [Resident 5], Zip tie call cord to half side rail on bed with enough length at end for him to have call cord to half rail on bed with enough lengths at end for him to have call cord in lap to prevent him from attempting to wrap call		then threatened to “throw himself on the floor” several times. He refused his medications and the nurse had to destroy them. 4/3/2017-Resident #5 requested that 911 be called because no one does anything for him. The nurse told him she couldn’t call 911 for that. He became extremely angry and attempted to “throw himself on the floor”. Again, when Resident #5 does not get his way, he displays a behavior. 9/1/2020- Resident #5 was sent to the ER. The resident was certain he had wax build up in his ears and demanded it to be examined. The doctor examined and stated everything was ok. Resident #5 asked for another otoscope exam to be done. The doctor refused. The resident became very angry and put the pulse oximeter cord around his neck and refused to leave his room until he got his way. He was forced to leave the ER and sent back to the facility. The hospital deemed this a behavior and not a suicide attempt (IDR attachment A). Resident #5 calmed down and didn’t have a plan to kill himself on return to facility. As with all the other examples cited herein, this resident has a history of attention-seeking behaviors when things do not go his way. 1/17/2023- Resident #5 became verbally and physically agitated with staff who were trying to assist	

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	cord around his neck. Medication as ordered. Notify physician as needed. Monitor quarterly for Medication GDR for psychoactive medication. Allow time to express feelings and provide validation and comfort as needed. SS to visit PRN. Document mood and behavior #1: I have altered mood related to dx of anxiety as evidence by yelling/screaming/cursing/ at staff, clenching my fist, repetitive yelling out for specific people and refused to talk when it is not what I want to hear and I attempt to wrap call cord around my neck for staff attention. Interventions: 1. Allow [Resident 5] time to express his feelings and provide validation and comfort, if unable to understand then get another staff member to assist. 2. Offer a sip of a drink to clear throat and make sure all basic needs are met, encourage use of two when repositioning to reduce random movements by [Resident 5]. 3. Make sure [Resident name] is aware that you are here to help him and he can trust you, maintain a calm consistent responses, change caregivers if needed. 4. Make sure [Resident 5] is safe and inform him that you will return when he has time to calm down and he is ready to have a conversation. During an interview, on 7/26/2023 at 3:07 P.M., CNA 2 indicated she was working on 6/6/2023 but was not assigned to Resident 5's room. She indicated in the past she had observed the resident wrap a cord around his neck. She indicated she had rehired 10 months ago, and he had only done this a few times in the past 10 months but a few years ago when she worked here, he often displayed that behavior. She indicated he would use the call light and/ or bed remote cord. During an interview, on 7/26/2023 at 3:10 P.M.,		him. He was using profanity and denied needing anything. Staff would leave the room and then he would put on his light again. The Resident then placed his call light around his neck and demanded staff to help him. The call light was attached to his bed as an intervention. Treatment for a UTI was also initiated. Resident denies wanting to kill himself. (IDR attachment B) 6/6/2023- Resident #5 was soiled and he didn't feel staff got to him quick enough. He then wrapped his bed rail pendant around his neck. Aide #3 entered the room and noted this. She removed the cord from his neck and notified the Nurse. (IDR attachment C) The Nurse came immediately to the Resident's room. He was very emotional but there were no red marks on his neck. (IDR attachment D). Social Services met with the resident and he calmed down and stated he didn't have a plan to kill himself. He was simply acting out because things did not go his way. This was, as demonstrated, his history. Due to his history of assessed attention seeking behaviors and the fact that the Resident has a BIMS of 15, the facility-initiated interventions for the resident. It is in the scope of the Nurse and the facility to initiate interventions regarding historical behaviors	

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	CNA 3 indicated via a phone interview she heard [Resident 5] yell and saw the bed remote cord was around his neck he would not let go, he said, "Let me die I don't want to do this anymore!" He was hysterically crying. He was pulling the remote cord and there were purple indents on his neck. He was lying flat on his back in bed and the cord was wrapped around the neck at least 2 times maybe 3 but definitely 2. That is the first time she had ever seen this happen. The nurse went in there to see if he was ok. She went to tell the Administrator who directed her to Director of Nursing and then told her to get the Social Worker. Afterwards if he put on the call light, we answered timely. He was not put on 1 on 1's or sent out. At 7/26/2023 at 3:28 P.M. the CNA called back she forgot to mention she was in the room during the Social Workers interview, and she stated multiple times to the resident, "Don't make me send you out I don't want to have to do that!" During an interview, on 7/26/2023 at 3:35 P.M., the Social Service Director indicated she believed the agency nurse contacted her about the cord around his neck. She went down to talk to him; he was very emotional and talked about why he was upset. She discussed ramifications when he puts a call light around his neck, let him express himself and reminisced which got him laughing, talking, and smiling. She did not call the doctor or psych (psychiatry) following the occurrence, but was going to schedule him on their next facility visit. She indicated the policy was to remove any harmful items, place on 1 on 1- or 15 minute checks and notify the doctor and psych. She did not remove the cord form the room, maintenance was to resecure it after she was done talking to the resident.		without Physician notification. The facility also requests the reference to resident #5 in F-580 be removed from the 2567. One of the final points of discussion is the Pendant cord (bed control cord) being a potential hazard. This cord is curled and would need to be stretched very tight to cause harm. (IDR attachment E). Aide #3 stated the cord was still curled around his neck. This would not have been tight enough to cause harm. Due to the resident's lack of strength, decreased mobility, and impaired dexterity the resident is unable to feed himself. (IDR attachment F). This explains why a coiled bed control would not be deemed a hazard. It would be like trying to hurt oneself with a plastic knife. It is important to note that there was a care plan intervention to secure the call light to the bed rail, as this is acknowledged in the survey report. Because the call light cord was no longer an instrument he could use, he no doubt used the bed cord. But this cord, as demonstrated, could not be of danger to him, and this emphasizes the resident's attention-seeking behavior. The surveyors imply the care plan was not followed because the bed cord was not secured to the bed rail, as was the call light cord, but that implication is not accurate. He could not and would not even	

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	During an interview, on 7/26/2023 at 3:49 P.M., the Director of Nursing (DON) indicated the Social Service (SS) informed her or the agency nurse. They said the resident wrapped the call light cord around his neck, so SS went down to talk to him. The DON had talked to him earlier to discuss his medications and what they were for. He was okay then. There was no problem with any of his medications. She went down and saw him after the event and he was in bed with his head of bed up watching TV. She did not see any discoloration around his neck. The call light cord was secured with zip tie so he could reach it but not pull it up. This was not the first time he did this. She was not sure how the zip tie got undone. The Maintenance Director refastened it. She did not have an investigation on this incident, and an unplanned occurrence was not filled out, but she would need to check the chart. He was okay after SS talked to him. The policy was to remove all objects that could cause harm and notify the physician and family. It should have been in the Progress Notes. During an interview, on 7/26/2023 at 3:53 P.M., the Maintenance Director indicated he had reattached the call cord to the assist/bed rails a couple times. He thought he did go last month after morning meeting at the request of the team, but did not recall any specific staff member asking him. The resident was calm and asked him to leave enough cord to go from the wall over his shoulder. I told him I couldn't do that, but then he asked if I could attach it to both the bed rail and the assist rail so it couldn't be moved. I asked him, "Don't you want it to be able to reach your lap?" and he said, "No" and indicated he would rather have it attached to the assist rail. He did not know how the zip tie got untied. He also did not indicate it was "an emergency" but usually when asked, he		potentially harm himself with this type of cord. Nevertheless, his behavior was assessed, appropriately care-planned, and the care plan interventions were appropriate and successful. Despite the fact that the cord did not present itself as a hazard, the situation could have been avoided if Resident #5 had been interviewed during the survey. Resident #5 states he was not asked about the incident and did not put the cord around his neck to cause harm, but to get help. (IDR Attachment G). In conclusion, the facility staff are very aware of how to react in a suicide situation. As noted in the 2567, it is alleged that 1 of 2 situations were not handled appropriately. Another incident happened during survey on 7/26/23 before the citation was given, and the surveyors observed the staff responded to this incident appropriately Also, staff responded appropriately back in 2016 when this behavior first began. This started a history of assessed attention seeking behavior that has lasted 7 years. The facility has kept the resident safe during this time frame. Resident #5's father is happy with the care we provide. A pattern of attention seeking behavior has been documented and successful interventions have been implemented since 2016.	

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	promptly responded to any request to check things out. He received a text from the DON on 6/6/2023 at 10:51 A.M., asking him to rezip the call cord in Resident 5's room. The text indicated he wrapped the cord around his neck. On 7/26/2023 at 4:10 P.M., the DON indicated that there was no unplanned occurrence or any documentation in the Progress Notes that the physician or family was notified. During an interview, on 7/26/2023 at 4:21 P.M., the Administrator indicated he could not recall who contacted him. He acknowledged the SS went to the resident's room and the resident indicated that he had no attempt to self-harm. "They tell you whether that is their intentions." He had a BIMS [Brief Interview for Mental Status] of 15 (cognitively intact) so he had no plan. He indicated management does investigations and he had sent the SS. On 7/26/2023 at 4:09 P.M., the Director of Nursing provided a policy titled, "Suicide Precautions", dated 6/12/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Procedure A. When residents verbalize the intent or demonstrate an attempt at suicide, the following procedures are recommended. I. ACTUAL: a. If the resident demonstrates an actual suicide attempt, emergency admit to acute care or inpatient psychiatric care will be requested. b. A designated staff person will be assigned to observe the resident at the bedside until relocation/transfer can be completed...." The immediate jeopardy that began on June 6, 2023 was removed on July 27, 2023 when the facility secured all environmental hazards within		Considering all of the facts that were available at the time of survey, it would be reasonable to conclude this was not a suicide attempt but an assessed attention seeking behavior. Considering this information, the bed pendant was not used as an instrument to cause harm, but a visual to get attention from the staff. Accordingly, this survey citation, as written, is not an accurate depiction of the facts and circumstances and is cited inappropriately. When you consider all the evidence, including both the resident's and the staff's long-history together due, in part, to implementation of successful and thus appropriate care plan interventions, you must conclude that this survey citation should be deleted or, at the very least, reduced in scope and severity.	

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	Resident 5's room and ensured all staff were inserviced regarding responding to suicide attempts and removing all potential environmental hazards. The non-compliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility will need to inservice any new or agency staff ongoing. The facility will continue to monitor Resident 5 as well as all residents who are at risk for self harm. 3.1-45(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			

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	Based on observation, record review, and interview, the facility failed to ensure the medication regimen was adequately monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident 21) Finding includes: The record for Resident 21, reviewed on 7/26/2023 at 9:01 A.M., indicated the resident was admitted to the facility on 8/14/2019 with diagnoses which included, but were not limited to: Alzheimer's disease late onset, chronic systolic congestive heart failure, localization related symptomatic epilepsy and epileptic syndromes, hypertensive heart and chronic kidney disease and hypothyroidism. The current Physician Orders for medications, included an order for Levothyroxine Sodium tablet 125 mcg (microgram), one table by mouth one time a day for low thyroid hormone. The current Physician Orders for laboratory testing indicated the resident was to have a TSH (Thyroid Stimulating Hormone) level test (a test utilized to determine correct effectiveness of thyroid medication), along with other testing, completed on 8/3/2023. The testing order indicated it was to be completed every 365 days. A previous Physician's Order, initiated on 1/19/2022 and discontinued on 4/28/2023, indicated a TSH level and other routine testing was to have been completed in March. The most recent TSH level for Resident 21, provided by the Medical Records staff on 7/31/2023 at 12:00 P.M., indicated the TSH level had not been completed since 10/14/2021.	F 0757	It is the policy of Miller's Merry Manor, New Carlisle, to ensure each resident's drug regime is free from unnecessary drugs. Resident 21's test to monitor TSH level was completed on August 8, 2023. Resident's need for the medication was confirmed by the lab results. All residents' plan of care has been reviewed to ensure adequate monitoring or indications for use, is in place to prevent unnecessary medications. All new admissions will be audited to ensure no unnecessary medications are being used by the clinical team. In addition, the Consultant Registered Pharmacist will be auditing new admissions with recommendations for lab work as appropriate. QAPI audit tool titled, "2023 Survey Audit Tool" (Attachment A) will be completed weekly x 8 weeks, monthly x 4 months. Any issues will be corrected immediately. Findings will be reviewed through the QAPI committee and after 6 months a determination will be made to continue, change the frequency of or discontinue the audits.	08/27/2023

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	During an interview with the Regional Nurse Consultant, on 7/31/2023 at 12:15 P.M., she indicated she could not locate a more recent TSH level test and there should have been one completed in the past year. She indicated there was no specific policy regarding TSH level testing, but the physician had ordered the test and it was not completed. The test was now scheduled to be drawn on 8/3/2023. 3.1-48(a)(3)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to ensure laboratory culture results were received before initiating an antibiotic for 3 of 4 residents reviewed for antibiotic stewardship. (Residents 5, 30, and 32) Findings include: 1. During a record review, completed on 7/28/2023 at 9:00 A.M., Resident 5 returned from the ER (Emergency Room) with an order for cephalexin 500 mg (milligrams) every 8 hours for 5 days for a UTI (urinary tract infection). A C&S (culture and sensitivity) report could not be found in the record.	F 0881	It is the policy of Miller's Merry Manor, New Carlisle, to ensure laboratory culture results are obtained before initiating an antibiotic, Resident 5 went out to hospital on 6-7-23 with acute flank/abdomen pain and returned with Cephalexin order which was completed. Resident 30's antibiotic treatment was completed in April 2023. Resident 32 was sent to hospital 7-27-23 after displaying delirium. He returned the same day with antibiotic orders. No culture was	08/27/2023

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	2. During a record review, completed on 7/28/2023 at 9:20 A.M., Resident 30 was noted to have a fall on 4/18/2023 and her urine had a foul odor. A C&S was done on 4/18/2023 and the physician ordered Macrobid 100 mg twice a day for 7 days on the same day. The results from the C&S were not received until 4/21/2023. 3. During a record review, completed on 7/28/2023 at 9:43 A.M., Resident 32 was sent to the ER and returned with an order for cephalexin 500 mg 3 times a day for 7 days. A C&S could not be found in the record. During an interview, on 7/28/2023 at 10:32 A.M., the IP (Infection Preventionist) nurse indicated in 2 of the cases, the residents returned from the hospital with the orders for the antibiotics, and in the 3rd case the physician gave the order by telephone. The facility used the McGreer Criteria for the use of antibiotics, and when a resident returned from the hospital with orders for an antibiotic, they would try to call the physician to clarify the order so as to follow the criteria, but sometimes they did not catch it in time. During an interview, on 7/28/2023 at 2:46 P.M., the DON (Director of Nursing) indicated the normal process was to wait until the C&S was returned before starting the antibiotic, and when the resident returned from the ER with an antibiotic order, they should have notified the attending physician for further instructions, but they did not in these cases. A current policy titled, "Antibiotic Stewardship" and dated 9/2/2019, provided on 7/24/2023 at the entrance conference, included, but was not limited to: " ...The facility's Infection Control Program has		obtained at the hospital and physician, when notified, chose to continue the medication. Resident's delirium resolved and he returned to his baseline within days. Any resident prescribed an antibiotic is at risk for this deficit practice. All antibiotic orders will be reviewed during the daily clinical meeting to ensure McGeer criteria is met for the use of antibiotics. If a true infection cannot be identified based on criteria and culture results do not confirm, the prescriber will be contacted with a request to stop the antibiotic. Documentation will be placed in the electronic medical record. All nurses will be inserviced on August 22 or 23rd about the true infections based upon the McGeer criteria and need for culture results prior to initiating an antibiotic or completing. The audit tool entitled, "Antibiotic Stewardship" (Attachment C) was developed and completed for all new antibiotic orders for 2 months. Findings will be reported in the QAPI committee meeting monthly as part of the Infection Control and Prevention program. QAPI committee will determine the frequency of audit completion.	

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	defined standards outlining specific clinical criteria for identification of infections, action plans to administer when infections occur and a surveillance program that aggressively monitors and implements procedures to treat and prevent future outbreaks. One of these procedures includes judicial and appropriate use of antimicrobial agents. Collaboratively, with the Medical Director, Resident's Attending Physicians, the Consultant Pharmacist and the Administration of each facility, every effort will be made to prevent the misuse or overuse of antimicrobials ...." A copy of the McGreer Criteria was attached to the policy.			