STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 00 B. WING	06/05/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 30, 31 and June 1, 2 and 5, 2023 Facility number: 000299 Provider number: 155676 AIM number: 100286940 Census Bed Type: SNF/NF: 54 Residential: 12 Total: 66 Census Payor Type: Medicare: 4 Medicaid: 46 Other: 4 Total: 54 Thesevdeficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 13, 2023.	F 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Gregg Jackson	Administrator	06/30/2023

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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	recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when a resident was prescribed an antipsychotic medication for 1 of 1 resident reviewed for PASARR. (Resident 35) Finding includes: The record for Resident 35 was reviewed on 6/2/23 at 9:20 a.m. Diagnoses included, but were not limited to, depressive disorder, delusional disorders, Alzheimer's disease with late onset, dementia in other diseases, and anxiety disorder. A diagnosis of delusional disorder was added on 7/29/19. A PASARR level I, dated 4/30/21, indicated the resident had diagnoses of major depressive disorder, psychotic delusional disorder, and dementia. A physician's order, dated 10/13/22, indicated risperidone (an antipsychotic medication) 0.25 mg (milligram) at bedtime and hold on Mondays and Thursdays related to delusional disorder. During an interview, on 6/02/23 at 11:10 a.m., the	F 0644	1. One resident was affected. The SSD submitted a PASRR status change for this resident on 6/2/23. The Notice of PASRR Level I Screen Outcome notice was completed on 6/6/23 and determination is Dementia/MI Exclusion. There were no PASRR recommendations. The PASRR Level I Screen Outcome document was uploaded to the clinical record. 2. A 100% resident audit will be completed to determine if any residents require a PASRR status change. SSD will complete PASRR changes by 6/30/23. PASRR documents will be maintained in the resident clinical record. The SSD will follow up on the PASRR recommendations and care plan the recommendations. The SSD will review the PASRR Level I and II and complete Status Change Level I Assessments as needed at the beginning of the month and mid-month so the	07/01/2023

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	Social Service Director indicated a Level II was not completed when the resident started on an antipsychotic medication. The Level II should have been completed and it was overlooked. During an interview, on 6/05/23 at 10:50 a.m., the Assistant Director of Nursing (ADON) indicated she thought the resident had diagnoses of schizophrenia and bipolar for the risperidone order. She reviewed the chart, and the resident did not have those diagnoses and a Level II was not updated after an antipsychotic was started. A PASARR policy was not provided by the facility. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		Status Change forms will be up to date within 14-15 days of the changes. The SSD will complete Status Changes for residents with new psychotropic medication orders, those with a new mental health diagnosis added, resident that have a significant change in mood or behavior symptoms and residents that have been admitted to behavior health hospital - if the hospital did not complete the new Level I form. PASRR in-service education will be provided for Admissions Coordinator, SSD and MDS Coordinator by 6/30/23. SSD will complete PASRR audits monthly for the next 90 days and then quarterly for the following 6 months. SSD will submit results in QAPI.	
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			

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	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 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 interview and record review, the facility failed to update care plans for long-term antibiotic therapy for 1 of 1 resident reviewed for care plans. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 6/1/23 at 10:46 a.m. Diagnoses included, but were not limited to, cellulitis, depressive disorder, anxiety disorder, lymphedema, and peripheral vascular disease. A physician's order, dated 11/28/21, indicated Cephalexin (an antibiotic) 500 mg (milligram) capsule, give 2 capsules twice a day. A care plan, dated as revised 2/2/23, indicated the resident suffered from lymphedema and had chronic cellulitis. Interventions included, but were not limited to, labs as ordered, encourage to elevate legs, skin assessment weekly, and medications as ordered. A care plan for the long-term antibiotic therapy was not located.	F 0657	1. Care Plan for Resident 7 was immediately updated to include long-term Antibiotic use. 2. Any resident on long term antibiotic use has the potential to be affected. Audit was completed and there is no other long-term antibiotic use in the facility. 3. Audits with MDS Schedule will be implemented. The MDS Coordinator will be responsible for updates, revisions or completion of comprehensive care plans. Placed on monthly IDT Agenda for 3 months. Full Audit of Care Plans will be completed by 6/30/23. Weekly audits with MDS Completion starting 7/7/23 and will be completed for 3 months. 10% of MDS completed monthly to be audited for 3 months. Reviewed Care Plan Policy with IDT. 4. Placed on monthly IDT Agenda	07/01/2023

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	During an interview, on 6/5/23 at 11:05 a.m., the Assistant Director of Nursing (ADON) indicated a resident on antibiotic medications should have a care plan. The resident was being seen by the Infectious Disease physician and was on long-term antibiotic therapy. The ADON was not aware the resident did not have a care plan for long-term antibiotic therapy. During an interview, on 6/2/23 at 10:34 a.m., LPN 6 indicated the resident had been on an antibiotic for a long time. She was being seen by an Infectious Disease physician and was on Keflex (an antibiotic) 500 mg twice a day for a few years. A policy, titled "Care Plan," received by the Social Services Director on 6/5/23 at 12:02 p.m., indicated "...It is the policy of Milner Community Health Care that resident care plans will be in place according to the schedule outlined below...Upon admission a care plan will be initiated to reflect the care to be given to individual resident...Within 72 hours the following care plans will be initiated if applicable...3. Skin Integrity...Within 7-14 days of admission the remainder of the care plans will be initiated by MDS, Social Services, Activities, and Dietary. Care plans will be updated as the residents condition warrants...." 3.1-35(b)(1)		for 3 months. Review audits in QAPI meetings for next 6 months.	
F 0688 SS=E Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure a resident received a splint device recommended by physical therapy, to obtain physician orders for braces/splint devices and to follow physician's orders for splint devices for 4 of 4 residents reviewed for position and mobility. (Resident 10, 104, 5 and 38) Findings include: 1. During an interview and observation, on 5/30/23 at 12:41 p.m., Resident 10 indicated she had pain in the left ankle, and it was a new pain. The left ankle appeared contracted, and the right ankle appeared like it may be contracted also. During an observation, on 6/1/23 at 9:34 a.m., the resident was sitting up in a wheelchair in her room, her feet were on the footrests of the wheelchair. She did not have a splint or brace in place to her legs or feet. Her ankles were bent inward. During an observation, on 6/5/23 at 10:07 a.m., the resident was sitting up in a wheelchair in her room	F 0688	1. Resident 10 was picked up by therapy again to assess splints. Resident 104 order placed for brace, apply in AM and remove at HS. Resident 5 order and care plan implemented. Resident 38 order adjusted per resident preferences to wear splints only at night. 2. All residents have the potential to be affected, residents on therapy in the last 6 months audited for missing splint recommendations. Residents with splint orders audited for accuracy and correct splints. 3. Section on the clinical meeting minutes added for therapy to track new splint and other appliance recommendations. As a double check, splints or new appliances will be specifically discussed in Medicare meeting weekly. Nurse education done on accuracy of	07/01/2023

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	and her feet were on the footrests of the chair with her ankles bent inward. The ADON (Assistant Director of Nursing) was present for the observation. The record for Resident 10 was reviewed on 6/2/23 at 2:25 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, contracture of the right hand, and generalized muscle weakness. A care plan, dated 4/5/2018, indicated the resident was at a risk for pain due to immobility, chronic pain, and contractures. Interventions included, but were not limited to, therapy as ordered. A care plan, dated 4/6/2018, indicated the resident needed assistance with ADLs (activities of daily living) related to contractures and dementia. The interventions included, but were not limited to, refer to therapy as needed. A physical therapy discharge summary, dated 7/25/22 through 9/15/22, indicated the resident was to use multi-podus boots (a device for contractures of the foot and ankle) while she was in the wheelchair to position her ankles in a neutral position. She was also to wear the boots while in bed for extended periods of time during the day. During an interview, on 6/5/23 at 10:09 a.m., the ADON indicated the resident's ankles did look contracted and she would look at the physical therapy notes. During an interview, on 6/5/23 at 10:31 a.m., the MDS Coordinator indicated the resident was seen in September 2022 by physical therapy and they recommended multi-podus boots for her ankles.		documentation. 4. Weekly audit to be done to ensure that resident splints are on at appropriate times, care plans and orders are in place for 6 months. Will review clinical minutes, audits and Medicare meeting information sheets in QAPI meetings to assess for further interventions for 1 year.	

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	The resident did not receive the boots and there was no physician's order for the boots. There was a miscommunication between the therapy department and nursing staff about the boots. 2. During an observation and interview, on 5/30/23 at 1:24 p.m., Resident 104 was observed to have a brace on her left lower leg, and she indicated she wore the brace all the time including when she was in bed. The record for Resident 104 was reviewed on 6/1/23 at 9:53 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) and hemiparesis (muscle weakness or partial paralysis) following a cerebral infarction, dementia, and type 2 diabetes. A physician's order, dated 5/30/23, indicated for physical therapy to evaluate and treat. There was no physician's order for the brace and no instructions on when to put on and remove the brace. A care plan, dated 5/28/23, indicated the resident needed assistance with ADLs due to the cerebrovascular accident with left sided weakness. A care plan, dated 5/28/23, indicated the resident was at a risk for pain due to a history of a stroke with left sided hemiparesis. The resident wore a brace on her left leg. The care plan did not include when the brace was to be put on or taken off. During an interview, on 6/1/23 at 1:56 p.m., the ADON indicated the resident was to wear the			

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	brace when the resident was up. There was not a physician's order for the brace. During an interview, on 6/2/23 at 12:15 p.m., the ADON indicated the resident's initial paperwork upon admission did not include the brace and this was the reason the physician's order did not get included for the brace.3. During an interview and observation, on 5/21/23 at 1:45 p.m., Resident 5 was observed to have boots on her lower feet, and she indicated it was for foot drop (difficulty lifting the front part of the foot). The record for Resident 5 was reviewed on 6/1/23 at 9:17 a.m. Diagnoses included, but were not limited to, MS (multiple sclerosis), paraplegia, rheumatoid arthritis, age related osteoporosis, and general muscle weakness. A physician's order, dated 3/24/17, indicated to assist the resident to complete active and passive range of motion to upper and lower extremities twice per day. A physical therapy discharge summary, dated 12/23/22 through 1/17/23, indicated the resident should wear podus boots as needed when up out of bed. The physician orders did not include a splint or boot device to go on her feet. During an interview, on 6/1/23 at 10:23 a.m., LPN (Licensed Practical Nurse) 3 indicated the resident wore boots for pressure relief and the LPN could not find a physician's order for the boots. During an interview, on 6/2/23 at 12:15 p.m., the ADON indicated the resident had been wearing the boots and there were no physician's orders for			

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	the boots. 4. During an interview and observation, on 05/31/23 at 10:19 a.m., Resident 38 was observed to have damp cloths next to her which the resident indicated were for her contracted hands. When asked about wearing splints for her contractures, the resident indicated the splints had been lost for a month. The record for Resident 38 was reviewed on 6/01/23 at 1:24 p.m. Diagnoses included, but were not limited to, disease of the spinal cord, quadriplegia (paralysis of all 4 limbs), and age-related osteoporosis. A physician's order, dated 7/29/21, indicated to apply a palm guard (a type of splint) to the left hand at night and to remove the splint in the morning and to apply a right-hand splint in the morning and remove it at night. A care plan, dated 12/20/22, indicated the resident was to receive assistance applying the hand splints and removing the splints as the physician's orders indicated. A MAR (medication administration record), dated 05/01/23 through 05/31/23, indicated the right-hand splint was applied each morning by the staff. The staff signed the MAR, on 5/31/23, to indicate they placed the splint on the right hand although the resident was not wearing the splint. During an interview, on 6/2/23 at 12:19 a.m., the ADON indicated she was aware staff members were signing the application of hand splints in the morning even though they had not applied the			

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	splints. During an interview, on 6/2/23 at 9:57 a.m., CNA (Certified Nursing Assistant) 4 indicated the resident did not wear the splints in the morning. During an interview, on 6/2/23 at 9:59 a.m., RN (Registered Nurse) 5 indicated the resident did not wear the splints in the morning and would only wear the splint at night. A current policy, titled "CONTRACTURE PREVENTION POLICY AND PROCEDURE", dated 5/13/19 and received from the ADON on 6/5/23 at 11:50 a.m., indicated "...FOLLOW SPLINT SCHEDULE AS ORDERED IF RESIDENT HAS SPLINTS...." 3.1-42(a)(2)			
F 0689 SS=G 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 interview and record review, the facility failed to ensure a resident was free from injury while using a stand-up lift during a transfer for 1 of 2 residents reviewed for accident hazards. (Resident 54). Resident 54 received an acute left mid clavicle fracture during a stand-up lift transfer. Finding includes:	F 0689	1. At the time of the incident, resident was evaluated by therapy and deemed appropriate for a Hoyer lift, 2. All residents have the potential to be affected, residents who use the stand-up lift have been	07/01/2023

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	A FRI (facility reported incident), dated 1/14/23 at 8:30 p.m., indicated Resident 54 was transferred with a stand up lift and let go of the lift which caused her arms to go over her head. The resident felt something pop at the time although it did not hurt. The resident later complained of pain and was evaluated at the emergency room. She was diagnosed with a fracture of the left clavicle. The record for Resident 54 was reviewed on 6/1/23 at 1:34 p.m. Diagnoses included, but were not limited to, chronic kidney disease stage 3, type 2 diabetes mellitus, right heart failure, macular degeneration, edema, osteoarthritis, and pain in the right knee. A care plan, dated 5/16/22, indicated the resident was at a risk for falls due to an unsteady gait. The interventions did not include the use of a stand-up lift. A care plan, updated on 11/11/22, indicated the resident was at risk for falls due to an unsteady gait and the need for extensive assistance with all transfers. The goal was for the resident to have no fall related injuries through the next review. The interventions included, but were not limited to, keep the call light within reach and to provide assistance to transfer as needed. The interventions did not include a stand-up lift. A care plan, dated 11/11/22, indicated the resident needed assistance with activities of daily living due to muscle weakness, and frozen shoulders (a condition where the shoulder stiffens and causes reduced mobility of the shoulder).		assessed by therapy for safety during use. 3. Policy updated to include IDT monitoring of residents change of conditions and hospital stays to initiate therapy referrals and re-evaluation of lifts. Staff in-services on lifts, new policy and specifically only therapy can clear a resident to use the stand-up lift. 4. List evaluation or re-evaluation added to clinical meeting minutes. Admission check list line added to remind staff that only Hoyer lift may be used until therapy evaluation for stand-up lift. QAPI to review the clinical meeting minutes for lift use to assess if further interventions are needed for 1 year.	

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MILNER COMMUNITY HEALTH CARE	370 E MAIN ST ROSSVILLE, IN 46065

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	A progress note, dated 1/9/23 at 10:12 p.m., indicated the resident was returned to the facility by ambulance. The resident was a 2 person assist to get into her wheelchair. The resident was very weak and not standing very well. A progress note, dated 1/10/23 at 2:50 p.m., indicated the resident required 2-3 persons for assistance with transferring and toileting. A social services progress note, dated 1/12/23 at 1:07 p.m., indicated the resident had an overall health decline. A progress note, dated 1/12/23 at 6:20 p.m., indicated the resident was a 2 person assist with activities of daily living and 2 persons assist with transfers with a mechanical lift. The resident was having a difficult time adjusting to the change in mobility since her hospital stay. The resident was not able to propel herself in the wheelchair. A progress note, dated 1/12/23 at 9:46 p.m., indicated the resident was alert to self and place although she had some forgetfulness and confusion. The resident could not remember taking her medication. She was total care per staffing. A progress note, dated 1/13/23 at 5:47 p.m., indicated the resident was a 2 person assist with activities of daily living and 2 persons assist with transfers with a mechanical lift. The resident was not able to propel herself in the wheelchair. A progress note, dated 1/15/23 at 1:34 p.m., indicated the resident's son came to visit and the resident reported she was dropped by the staff at 5:00 a.m., while getting her weight and her left shoulder was hurting and had never bothered her			

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	before. The resident was not able to stand due to the left shoulder pain. A progress note, dated 1/16/23 at 12:16 a.m., indicated the x-ray results were an acute left mid clavicle fracture. The physician was notified, and the resident was sent to the emergency room for evaluation and treatment. An Occupational Therapy evaluation and plan of treatment, dated 1/11/23 through 2/9/23, indicated a goal was for the resident to be improve the ability to safely transfer to a standing position from sitting in a chair, wheelchair or on the side of the bed with supervision or touching assistance without physical exertion. On 1/11/23, the resident required substantial/maximal assistance for this task. Another goal was for the resident to demonstrate stand balance with 30 seconds tolerance to increase toileting. On 1/11/23, the resident was able to demonstrate less than 30 seconds of standing balance. The resident had an impaired range of motion and strength to both of her upper extremities. A witness statement by CNA 11, dated 1/2/23, indicated the resident was ready to get washed up and ready for the day. CNA 11 asked CNA 10 to help with getting the resident in a standing position. After a few failed attempts to get into a standing position, the nurse was asked if the stand-up lift would work because the Hoyer lift was out of the question since there was no sling under the resident. The resident was strapped into the lift and stood up without any issues. CNA 10 indicated to hurry and put the resident down, then the resident's arms went up and her bottom landed perfectly in her wheelchair. The resident did not complain of pain.			

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	The date of the witness statement did not match with the FRI date of 1/14/23. An employee witness statement by LPN 12, dated 1/16/23, indicated she saw two CNAs on 1/15/23 trying to transfer the resident into the weight chair and they called for a third CNA to try to get the resident to stand. The resident stated she could not stand up due to her left shoulder hurting. The CNAs indicated the resident had trouble transferring since she came back to the facility from the hospital, and they had to use 2-3 CNAS and the stand-up lift. It was suggested for a Hoyer lift to be used and the resident stated she did not want to use the Hoyer lift. An employee witness statement by CNA 9, dated 1/17/23, indicated on January 15, 2023, a sit to stand lift was used on the resident. CNA 9 and another not identified CNA were in the room and asking the resident not to let go of the bars while she was being transferred from the wheelchair to her recliner. The resident was sliding so the two CNAs quickly sat the resident down in the recliner to avoid a fall. The resident did not complain of pain or seem to be hurting after she sat down. The ADON was not able to clarify if this was a second attempt at using the stand-up lift since the resident was reported to be sliding into the recliner instead of the wheelchair in the first witness statement dated 1/2/23. An employee witness statement by CNA 10, not dated, indicated the resident needed to use the restroom. CNA 10 and CNA 11 were trying to transfer the resident and the resident was not able to help stand up. CNA 10 asked the nurse what to do and the nurse said to try the stand-up lift. The resident stood up and held onto the bar. When			

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	she was finished using the toilet the resident was raised up to clean her bottom. The resident let go of the bars and tucked her arms causing her to slide out of the sling. She landed in the wheelchair. A timeline of the incident was given by the ADON on 6/2/23 at 3:00 p.m. The timeline indicated the following: a. On 1/3/23, the resident had a decline in condition and weakness and the physician ordered a therapy evaluation. b. On 1/4/23, the resident was sent to the emergency room due to a decline in condition and increased shortness of breath and weight gain. c. On 1/9/23, the resident returned from the hospital. d. On 1/10/23, a therapy evaluation was completed. e. On 1/14/23, a CNA indicated the resident let go of the stand lift during a transfer and slid through the sling onto her chair. The resident denied pain. f. On 1/15/23 in the early morning, staff were attempting to weigh the resident and she complained of shoulder pain. g. On 1/15/23 in the afternoon, the family spoke to the nurse about the resident complaint of being dropped. The physician was in the facility and assessed the resident and ordered rays. h. On 1/16/23, the X-ray results showed a fracture. During an interview, on 6/2/23 at 12:21 p.m., the ADON (Assistant Director of Nursing) indicated the resident had let go of the stand-up lift, she was positioned over the recliner or the wheelchair and fell into the chair. The lift kind of pushed on her shoulders and she did not complain of pain originally. She was progressively getting weaker. The staff did not report the incident as a fall since the resident did not actually fall. The X-rays were			

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	obtained 24 hours after the incident. The resident had a decline in condition, had been to the hospital and then back to the facility and the care plan had not been revised yet to reflect her change in condition. During an interview, on 6/2/23 at 3:23 p.m., the ADON indicated the resident had a therapy evaluation and there was no approval for the stand-up lift. Nurses could make a determination as a nursing measure for the safest way to transfer a resident until an evaluation could be obtained. Before the incident, the IDT (interdisciplinary team) was supposed to approve the stand-up lift and after the incident the policy was changed for only therapy to evaluate for a stand up lift transfer. There were no progress notes to show the IDT had approved the stand up lift. A policy, titled "Mechanical Lifts," dated 1/20 and received from the ADON on 6/2/23 at 10:15 a.m., indicated "...To ensure the safety for all residents while using a mechanical lift; to prevent injury, and to help protect the resident and staff...These procedures are designed to prevent resident injuries during the use of mechanical lifts, either the stand-up lift or the Hoyer [sling] lift. It is critical that all health care professionals' practice safe lifting procedures with all mechanical lifts. Failure to utilize proper procedures with the mechanical lifts will result in disciplinary action, which may include termination...Step action...two types of residents lifts: the stand-up lift and the Hoyer [or sling] lift. These lifts are available for use by trained employees for all residents that have an appropriate care plan...The IDT team are responsible for identifying the residents whom require a mechanical lift. This identification will be documented in the resident care plan, and the resident profile...The IDT team will make changes			

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	to the type of lift required as necessary due to changes in the resident condition. Changes will be updated in the resident care plan and the resident profile... Specific guidelines for the stand-up lift...Resident should be alert, weight bearing, and able to follow simple one-step commands...Resident should be able to hold onto the lift bar...Resident should be able to sit without support...." A current policy, titled "FALL PREVENTION & MANAGEMENT," dated as reviewed on 10/13/21 and received from the ADON on 6/5/23 at 11:34 a.m., indicated "...It is the policy of this facility that each resident will be assessed for the potential risk for falls upon admission/re-admission and with any change in condition...If a resident is identified to be at risk for falls a care plan will be developed with appropriate interventions that will assist in reducing the risk of falls and/or fall related injuries...The interventions will be initiated...The care plan and interventions will be evaluated for continued appropriateness after any resident fall and/or at least quarterly...." 3.1-45(a)(1)			
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			

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	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 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, interview and record review, the facility failed to ensure an indwelling catheter bag and tubing were off the floor for 2 of 2 residents reviewed for indwelling catheters. (Resident 10 and 38) Findings include: 1. During an observation, on 5/30/23 at 11:55 a.m., Resident 10 was in the dining room. The resident's catheter was placed in a dignity bag touching the floor and the tubing was laying on the floor under the wheelchair. The record for Resident 10 was reviewed on 6/2/23	F 0690	1. Resident 10 and Resident 38 have clean bath basins under the foley bad so if the resident's bed is in low position it will rest in the basin. 2. Other residents will foley catheters have the potential to be affected. Other residents with foleys have been audited and basin placed if bed is lowered enough for foley bag to touch the floor. 3. Policy revised to add checking	07/01/2023

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	at 2:25 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder, generalized anxiety disorder, contracture of the right hand, chronic obstructive pulmonary disease, major depressive disorder, Alzheimer's disease with late onset, chronic pain, retention of urine, and history of urinary tract infections. A care plan, dated 4/6/18, indicated the resident was at risk for infection related to use of a catheter due to the diagnosis of neurogenic bladder and urinary retention. Interventions included, but were not limited to, no symptoms of infection through next review, catheter care as ordered, change catheter every 30 days and prn (as needed) as ordered, encourage fluid intake, observe for signs of infection, and notify my doctor as needed, and catheter irrigation as ordered. A physician's order, dated 4/3/23, indicated catheter care every shift. During an interview, on 5/30/23 at 12:06 p.m., LPN 7 indicated the resident should not have the catheter bag or tubing touching the floor. The catheter bag touching the floor was unsanitary and the resident could develop an infection. During an interview, on 6/5/23 at 9:53 a.m., the Assistant Director of Nursing (ADON) indicated QMA 8 did not tell her about the resident's catheter touching the ground. The ADON indicated the catheter was in a dignity bag and the bags were cloth and not an impermeable barrier. 2. During an observation of catheter care with QMA (Qualified Medication Aide) 8, on 06/02/23 at 2:07 p.m., Resident 38's bed was in a low position which caused the catheter bag to touch the floor. QMA 8 indicated the catheter bag should not be touching the floor. The resident wanted her bed in		if foley bag touched floor when bed is in low position and is so to place a bath basin under foley bag to avoid contact with the floor. All staff educated on revised policy. 4. Foley catheters bag audits to be done daily for 30 days, then weekly for 2 months then randomly for another 2 months. Audits to be reviewed in QAPI to assess need for further intervention for 1 year.	

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	the lowest position and QMA 8 would talk with ADON about how to prevent the bag from touching the floor. During an observation, on 06/05/23 at 9:46 a.m., the resident's bed was in the lowest position and the catheter bag was touching the floor. The record for Resident 38 was reviewed on 6/01/23 at 1:24 p.m. Diagnoses included, but were not limited to, disease of the spinal cord, quadriplegia (paralysis of all 4 limbs), and age-related osteoporosis. A care plan, dated 10/07/20, indicated the resident was to have Foley catheter care every shift and as needed. A physician's order, dated 5/19/23, indicated to change the Foley (indwelling urinary catheter) on the 19th on the day shift, using an 18 French (specific size), 30 cubic centimeters (size of catheter bulb). During an interview, on 06/05/23 at 9:46 a.m., the ADON indicated she was not aware the resident's catheter bag was touching the floor when the bed was in the lowest position. The catheter bag would need to be moved to prevent from it touching the floor. A current policy, titled "Catheter Care," dated as reviewed on 1/30/2016 and received from the Administrator on 5/30/23 at 3:10 p.m., indicated "...Catheter care is performed appropriately and safely to prevent complications caused by the presence of an indwelling catheter...The urinary drainage bag should be secured to the bed or chair below the resident's bladder, so that the urine flows from the bladder into the bag by			

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	gravity. Never let the drainage bag touch the floor, which is considered an 'unclean' area...." 3.1-41(a)(2)			
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 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			

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	§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 prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure PRN (as needed) antianxiety medications were prescribed only for 14 days and reviewed for the need to continue the use for 1 of 5 residents reviewed for unnecessary medications. (Resident 35) Finding includes: The record for Resident 35 was reviewed on 6/2/23 at 9:20 a.m. Diagnoses included, but were not limited to, anxiety disorder, delusional disorders, Alzheimer's disease with late onset, dementia in other diseases, and depressive disorder. A physician's order, dated 5/6/23 and open ended, indicated to give lorazepam (an antianxiety medication) 0.5 mg (milligrams) every 6 hours as needed. The Medication Administration Record (MAR), dated 5/01/23 through 6/5/23, indicated the resident received the PRN lorazepam seven times after the 14th day.	F 0758	1. One resident was affected. This resident's PRN anti-anxiety medication order was discontinued on 6/7/23. 2. All residents medication orders were reviewed to identify those with PRN psych med orders. PRN psych med orders beyond 14 days were discontinued or changed to routine medications with physician's orders. 3. A revised facility policy was implemented requiring a 14 day stop date on psychotropic medications. Nursing was educated on the new policy for PRN psych med orders to be written with a 14 day stop date. The NetSolutions electronic medical record system discontinues 14-day PRN med orders from the EMAR list after the 14th day. In-service education	07/01/2023

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	During an interview, on 6/5/23 at 10:50 a.m., the Assistant Director of Nursing (ADON) was aware the PRN (as needed) lorazepam was not renewed after 14 days. The facility had overlooked the medication renewal and should receive a new order every 14 days. A current policy, titled "Gradual Dose Reduction," dated 7/18/18 and received from the Assistant Director of Nursing Services on 6/1/23 at 3:25 p.m., indicated "...in consultation with pharmacy consultant, will review resident medications and send recommendation to resident's primary care physician for possibility of medication dose reduction...Pharmacy consultant reviews all resident drug regimens monthly with documentation provided on Pharmacy Consultant Drug Regimen Review...Recommendations, if provided, will be sent to physician for review...." A current policy, titled "Psychotropic Medication Policy," dated 7/24/19 and received from the Assistant Director of Nursing Services on 6/5/23 at 11:54 a.m., indicated "...Milner Community Health Care and its providers will use psychotropic medications appropriately working with the IDT to assure appropriate use, evaluation and monitoring per state and federal guidelines...will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review of continued need, appropriate dosage, side effects, and risks and/or benefits of such medications...Psychopharmacological medications will never be used for the purpose of discipline or convenience...Psychotropic medications include: anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs...."		was provided to SSD, Nursing and Hospice staff on F758 completed on 6/28/23. 4. The SSD will review PRN psych med orders vis the NetSolutions order report twice weekly. SSD will contact the prescriber regarding discontinuing the medication or documenting a rationale for the continued use and the expected duration of the PRN order. The Pharmacy Consultant will review all drug regimens monthly with documentation provided on the Pharmacy Consultant Drug Regimen Review. Recommendations will be forwarded to the physician for review. Nursing will follow up on the physician recommendations upon receipt. The SSD will submit the PRN psych med review report monthly to QAPI for the first 90 days and then quarterly for the next 6 months.	

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	3.1-48(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the dishwasher had reached and maintained the appropriate temperature during the wash and final rinse cycle and the ice machine was clean from a black substance inside the machine. This deficient practice had the potential to affect 54 of 54 residents who received food from the kitchen. Findings include: 1. During an observation, on 5/30/23 at 11:27 a.m., the Dietary Manager (DM) ran the facility	F 0812	1. The ice was removed from the ice machine and thoroughly cleaned per manufacturer's instructions. GFS was notified and came to replace the board on the booster heater. Paper products were used until the replacement was complete and the machine running properly. 2. There is only one ice machine and one industrial dishwasher in the facility.	07/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 00 B. WING	06/05/2023

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

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	dishwasher through a cycle. The wash temperature was 120 degrees, and the final rinse was 152. The DM completed a second cycle, and the temperature was 124 degrees for the wash cycle and 152 degrees for the final rinse cycle. 2. During an observation, on 5/30/23 at 11:30 a.m., inside the ice machine was approximately a 6-inch black line across the top of the white plastic strip with water spots around the black line. The black line was wiped with a napkin and a dark black area appeared on the napkin. The DM did not know when the ice machine was last cleaned or what the black substance was. 3. During an observation, on 5/30/23 at 12:00 p.m., the residents were observed eating off non disposable dishes, drinkware, and silverware. A Daily Data Sheet indicated the following: a. On 5/18/23 to 5/21/23, the dishwasher rinse temperatures were 130 degrees for the breakfast and noon meals. b. On 5/22/23, 5/27/23 and 5/29/23, the dishwasher rinse temperature was 130 degrees for the breakfast, noon, and evening meals. c. On 5/28/23, the dishwasher rinse temperature was 130 degrees for the evening meal. d. On 5/30/23, the dishwasher rinse temperature was 130 degrees for the breakfast and noon meals. A Service Manual from [name of appliance company] indicated the water requirements for the wash temperature was a minimum of 150 degrees Fahrenheit and the final sanitizing rinse temperature was a minimum of 180 Fahrenheit. During an interview, on 5/30/23 at 11:30 a.m., the DM indicated the wash cycle should have been 150 degrees or higher and the final rinse cycle		3. A new monitoring procedure was implemented for both the ice machine and the dishwasher temperatures. The dietary staff were in-serviced on both procedures on 6/29/23 and 6/30/23. 4. The Dietary Supervisor will report on the monitoring procedure for the dishwasher temperatures and the ice machine cleaning to see if the preventive maintenance schedule for cleaning needs to be increased even though we are currently following manufacturer's recommended guidelines. The Dietary Supervisor will report to QAPI monthly for the first 90 days and quarterly for 1 year.	

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	should have been 180 degrees or higher. The facility had trouble with the temperatures for almost 2 weeks. During an interview, on 5/30/23 at 12:59 p.m., the DM indicated if the dishwasher was not at the right temperature, it would not sanitize correctly. This could cause a foodborne illness and the ice machine needed to be cleaned and sanitized. The DM was aware the residents were eating off non disposable dishes, drinkware, and silverware even when the temperatures were not reaching the appropriate temperatures. During an interview, on 5/30/23 at 1:08 p.m., the Assistant Director of Nursing (ADON) indicated if the dishwasher temperature did not reach the recommended temperature, they would call for service. The ice machine would be emptied by the Maintenance Department and the inside sanitized. The dishwasher not getting to the right temperature and the ice machine having black buildup could cause a food borne illness. During an interview, on 5/31/23 at 11:26 a.m., the DM indicated the dishwasher was not working last Friday and they called to have the dishwasher serviced. A current policy, titled "Dietary Department," dated as revised 9/22/22 and received from the Dietary Manager on 5/30/23 at 3:00 p.m., indicated "...Food services sanitation requirements as given in 410-IAC 7-15.1 are met. The dietary supervisor is responsible for seeing that these regulations are implemented, including, but not limited to the following...The cleaning schedules and procedures should be accessible to dietary employees and are followed by them...The cleaning schedule indicates areas of the dietary			

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	department which are to cleaned daily, weekly and monthly...." 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 30, 31 and June 1, 2 and 5, 2023 Facility number: 000299 Residential Census: 12 Milner Community Health Care was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on June 13, 2023.	R 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	