PRINTED: 12/18/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A						
CENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	uilding <u>00</u>	COMPLETED		
	155579	B. W	ING	11/30/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			7440 N COUNTY ROAD 825 E			
			1			

MILLER'	S MERRY MANOR	HOPE, IN 47246			
(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	RESOLUTION ON ESCHIPLING PRINCIPAL OR MATTER	mg		BATE	
Bldg. 00	This visit was for the Investigation of Complaints IN00422517. This visit included an Covid 19 Infection Control survey.	F 0000			
	Complaint IN00422517 - Federal/State deficiency related to the allegation is cited at F887.				
	Survey dates: November 29 and 30, 2023.				
	Facility number: 000286 Provider number: 155579 AIM number: 100291000				
	Census Bed Type: SNF/NF: 32 Total: 32				
	Census Payor Type: Medicaid: 20 Other:12 Total: 32				
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.				
	Quality review completed on December 6, 2023.				
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Erica Bowman HFA, LPN 12/13/2023

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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		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155579	ľ	UILDING	instruction 00	(X3) DATE COMPL 11/30/	ETED
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 7440 N COUNTY ROAD 825 E HOPE, IN 47246						
) ID EFIX AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		the resident or state been immunized; (ii) Before offering members are provided effects associated in the covided with the COVID-19 (iv) In situations we require multiple of resident represent provided with currest those additional dischanges in the beside effects associated effects associated in the covided with currest administration of a (v) The resident, restaff member has refuse a COVID-1 decision; (vi) The resident's documentation that the following: (A) That the resident representative was regarding the benefits and potent COVID-19 vaccing (B) Each dose of administered to the COVID-19 vaccing (vii) The facility marelated to staff COVID-19 related to staff COVID-19 vaccing (vii) The facility marelated to staff COVID-19 vaccing (viii) The facility marelated to staff COVID-19 vaccing (viiii) The facility marelated to staff COVID-19 vaccing (viiiii) The facility marelated to staff COVID-19 vaccing (viiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	COVID-19 vaccine, all staff vided with education efits and risks and potential stated with the vaccine; a COVID-19 vaccine, each sident representative in regarding the benefits and it side effects associated 9 vaccine; where COVID-19 vaccination doses, the resident, tative, or staff member is ent information regarding oses, including any nefits or risks and potential stated with the COVID-19 questing consent for any additional doses; esident representative, or the opportunity to accept or 9 vaccine, and change their medical record includes at indicates, at a minimum, ent or resident sprovided education thial risks associated with e; and COVID-19 vaccine e resident; or did not receive the educe to medical					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-							IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		î ,	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155579	B. WING		11/30	/2023	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			7440 N	ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 825 E IN 47246			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, and the second	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	regarding the ben associated with C (B) Staff were offer or information on vaccine; and (C) The COVID-11 related information Centers for Disea National Healthca Based on record revalued to provide Co in a timely manner immunizations. (Referring include: 1. The clinical record on 11/29/23 at 1:42 admitted on 09/11/2 assessment, dated 0 was cognitively into but were not limited and rib fractures. The "COVID-19 V. Information" record by the Administrator record indicated the and requested the Cadministered. The resident's representations.	ered the COVID-19 vaccine obtaining COVID-19 9 vaccine status of staff and as indicated by the se Control and Prevention's re Safety Network (NHSN). View and interview, the facility OVID-19 booster immunizations for 3 of 8 residents reviewed for esidents E, F, and H) rd for Resident E was reviewed P.M. The resident was 23. An Admission MDS 19/18/23, indicated the resident act. The diagnoses included, d to, diabetes, heart disease, accination Status, Consent & d, dated 09/11/23, was provided or on 11/29/23 at 3:39 P.M. The eresident had been educated COVID-19 vaccine be record was signed by the	F 08	887	F- 887 Covid-19 Immunization S/S=D It is the policy of Miller's Merry Manor to administer Covid-19 booster immunizations in a tiry manner. 1 Immediate action to corry the alleged deficient practice included Resident "E" record reviewed and is current with Covid-19 Comirnaty vaccine a November 15, 2023. Resider record reviewed responsible pelected to decline the Covid Vaccine Comirnaty on Novem 15, 2023. Resident "H" record reviewed and is current with Covid-19 Comirnaty vaccine a November 15, 2023. 2 All residents with signed vaccination consent forms had the potential to be affected by alleged deficient practice. All current residents clinical record were audited to ensure compliance of vaccination	y) mely ect as of nt "F" party nber d as of	12/01/2023

- dated 05/31/22, and

administration based on their

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	· /	JILDING	00	COMPL	
		155579	B. W	ING		11/30/2023	
			1	CTREET	ADDRESS SITY STATE ZIP SOP		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
MILLEDIA	S MEDDY MANIOR				COUNTY ROAD 825 E		
IVIILLER	S MERRY MANOR	·		HOPE,	IN 47246		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- dated 10/28/22, p	rior to admission.			consents. No findings noted d	uring	
					auditing process.		
		lacked documentation the					
		ed a COVID-19 booster since					
		ing admission on 09/11/23. The			3 To ensure the alleged		
	booster was not adı	ministered until 11/15/23.			deficient practice does not red	cur	
					all Licensed Nurses were		
		eillance Data Collection Form			in-serviced on "Resident		
		by the DON on 11/29/23 at 11:07			SARS-CoV-2 (Covid) Vaccine	and	
		adicated the resident tested			Post Vaccination Care"		
	positive for COVII	D-19 ON 11/16/23.			(Attachment A).		
	TI D M	6 00/01/22					
	_	s, from 09/01/23 to present,					
		ion the resident had been		4 To monitor the corrective			
	offered a COVID-1	19 booster prior to 11/15/23.			actions and ensure the allege		
	Th	.4.44 4:4: 1			deficient practice will not recu		
	_	eted, and discontinued			the DON/Designee will compl	ete	
		from 09/01/23 to present,			the QA Tool titled, "Covid	.:_	
		COVID-19 booster vaccine			Vaccines", (Attachment B). The		
	prior to 11/15/23.				tool will be completed daily (N	•	
	2 The clinical race	ord for Resident F was reviewed			for (2) weeks, followed by weeks	-	
		3 P.M. The resident was			for (4) weeks, then monthly for	. ,	
		23. A Quarterly MDS			months, and quarterly thereaf At the completion of this it will		
		11/08/23, indicated the resident			reviewed, in one year, by the	υ C	
		act. The diagnoses included,			Quality Assurance (QA) team	to	
	1 -	d to, Parkinson's disease and			determine the frequency of th		
	respiratory failure.	a to, I arkinson's disease and			audit. Any concerns will be	C	
	135phatory famare.				addit. Any concerns will be addressed immediately and h	ave a	
	The "COVID-19 V	accination Status, Consent &			Quality Assurance and Quality		
		d, dated 08/01/23, was provided			Improvement Action Plan	,	
		or on 11/29/23 at 3:39 P.M. The			completed. The action plan w	ill be	
	l -	e resident had been educated			reviewed at the monthly QAP		
	and requested the C	COVID-19 vaccine be			meeting with changes made a		
	_	record was signed by the			appropriate.		
	resident's represent	- ·			l		
	•				5 All systemic changes will	be	
	The resident had re	eceived the following COVID-19			completed on or before Friday		
	immunizations:	<u> </u>			December 01, 2023.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	NUMBER A. BUI		uilding <u>00</u>		COMPLETED	
		155579	B. W	ING		11/30/2023		
				CTDEET A	DDDEGG CITY CTATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD			
MULEDIO	NEDDY MANOD				COUNTY ROAD 825 E			
WILLERS	S MERRY MANOR			HOPE,	IN 47246			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	- dated 01/20/21,							
	- dated 02/17/21,							
	- dated 01/20/22, an	ıd						
	- dated 07/06/22, pr	ior to admission.						
	-							
	The clinical record	lacked documentation the						
	resident had receive	ed a COVID-19 booster since						
	07/06/22 or following	ng admission on 08/01/23.						
	The Infection Surve	eillance Data Collection Form						
	log was provided by	y the DON on 11/29/23 at 11:07						
	A.M. The record in	dicated the resident tested						
	positive for COVID	0-19 ON 11/20/23.						
	The Progress Notes	, from 09/01/23 to present,						
	lacked documentation	on the resident had been						
	offered a COVID-1	9 booster.						
	The current, comple	eted, and discontinued						
	physician's orders, f	from 09/01/23 to present,						
	lacked orders for a	COVID-19 booster shot.						
	3. The clinical recor	rd for Resident H was reviewed						
	on 11/29/23 at 3:28	P.M. The resident was						
	admitted on 09/29/2	23. An Admission MDS						
	assessment, dated 1	0/06/23, indicated the resident						
	was moderately cog	gnitively impaired. The						
	diagnoses included,	but were not limited to,						
	coronary artery dise	ease and chronic obstructive						
	pulmonary disease.							
	-							
	The "COVID-19 Va	accination Status, Consent &						
	Information" record	l, dated 09/29/23, was provided						
		or on 11/30/23 at 12:25 P.M.						
	_	d the resident had been						
	educated and reques	sted the COVID-19 vaccine be						
	_	ecord was signed by the						
	resident on 09/29/23							
	The resident had red	ceived the following COVID-19						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155579	B. W	B. WING		11/30/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>		7440 N	COUNTY ROAD 825 E		
MILLER'S	S MERRY MANOR			HOPE,	IN 47246		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	immunizations:						
	- dated 01/26/21,						
	- dated 02/24/21, an	d					
	- dated 01/13/23, pr						
	•						
		lacked documentation the					
		ed a COVID-19 booster since					
		ng admission on 09/29/23. The					
	booster was not adn	ninistered until 11/15/23.					
	Tl D N - 4	france 00/01/22 to manage					
	_	, from 09/01/23 to present, on the resident had been					
		9 booster prior to 11/15/23.					
	officied a COVID-1) booster prior to 11/13/23.					
	The current, comple	eted, and discontinued					
	-	From 09/01/23 to present,					
		COVID-19 booster shot prior to					
	11/15/23.	-					
	_	on 11/29/23 at 11:30 A.M., the					
		dents' consents for vaccines					
	paper hard charts.	sion agreements and on their					
	paper nard charts.						
	During an interview	on 11/29/23 at 11:11 A.M., the					
	_	ated no residents had been					
		ital for COVID-19 during this					
	recent outbreak.	-					
	-	on 11/29/23 at 3:35 P.M., the					
		en a resident was admitted and					
		nunizations the facility would					
		(Children & Hoosiers					
	_	stry Program) and see what					
		had and discuss with the what immunizations were					
	_	and needed at that time. The					
	-	MD and would get the order					
		es that specific resident					
	151 ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	as that specific resident					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155579	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE S COMPLE 11/30/2	ETED			
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		7440 N	STREET ADDRESS, CITY, STATE, ZIP COD 7440 N COUNTY ROAD 825 E HOPE, IN 47246					
PREFIX (EACH DEFICIEN TAG REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	D BE	(X5) COMPLETION DATE			
usually took about the vaccines in stock trouble getting vaccines in stock trouble getting vaccines in stock administered as ord. During an interview DON indicated she position since Augu "house stock" of the 11/13/23 and provides she indicated she house vaccines prior to 11 pharmacy had the be 11/01/23. During an interview Consultant Pharmacine have the vaccines where the vaccines decilities letting the On November 6,20 order for the vaccines where the vaccines were respectively brought it to and the vaccines were respectively brought it to and the vaccines were sent out in 24 to 48. During an interview Nurse Consultant in vaccine was not avait they would have a light pharmacy or use a light something their pharmacy or use a light pharm	or on 11/29/23 at 3:58 P.M., the had been in her current ast 2023. She had ordered a se new COVID-19 vaccines on ded a copy of the order receipt. ad not ordered any COVID-19 /13/23. She did not think their proosters available until won 11/29/23 at 4:20 P.M., the cist indicated the pharmacy did es available until November 1, sent correspondence to the m know they were available. 23, the pharmacy received the less. There was a delay because outed to the wrong queue. The or their attention on 11/13/23 ere sent out that night. When wed an order, it was usually							

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 11/30/2023			
	PROVIDER OR SUPPLIER	<u>I</u>	74	440 N	DDRESS, CITY, STATE, ZIP COD COUNTY ROAD 825 E N 47246	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Moderna will be av Vaccination remain COVID-19-related Vaccination also re the effects of Long during or following extended duration. COVID-19 vaccine updated COVID-19 this fall and winter. The current "Prever Coronavirus (COV was provided by the 1:27 P.M. The polic follow the guideling forth by the Indiana CDC,and other excontrol and prevent prevent the transmi COVID-19The cocommitteewill reguidance and reconcreate policies and COVID-19 as deen vaccination is encoresidents and visito staff and residentsphysician order and residents to stay up vaccine"	ntion and Containment of ID-19)" policy dated 09/08/23, e Administrator on 11/30/23 at ey indicated, "PolicyTo es and recommendations set a State Department of Health, experts in the field of infection ion and epidemiology in ssion and containment of					

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