STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING 00 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

(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. Survey dates: April 17, 18, 19, 22 & 23, 2024 Facility number: 000041 Provider number: 155102 AIM number: 100275400 Census Bed Type: SNF: 2 SNF/NF: 68 Total: 70 Census Payor Type: Medicare: 3 Medicaid: 46 Other: 21 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/1/24.	F 0000		
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident			

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

Bryan Zehr | Administrator | 05/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to ensure housekeeping maintained a sanitary room environment related to dust and floors not swept or mopped for 1 of 1 resident reviewed for environment. (Resident 42) Finding includes:	F 0584	F- 584 Safe/Clean/Comfortable Homelike Environment It is the policy of Miller's Merry Manor to provide a safe, clean, comfortable and homelike environment allowing residents to use his or her personal belongings	05/20/2024

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	During an interview and observation on 4/17/2024 at 11:06 A.M., Resident 42 indicated she did not feel her room was clean. They had one housekeeper that was fantastic but was no longer here. The other housekeepers cleaned the toilet, bathroom sink and took out the trash. They seldom mopped and swept the floors in the bedroom, and they did not dust. The blinds needed to be dusted, it's been at least 2 months. The blinds, picture frames, and shelves in the bathroom with angel figurines were observed to be dusty. During an interview and observation on 4/18/2024 at 1:19 P.M., Resident 42 indicated that staff had cleaned the bathroom and dry mopped the floors, but did not wash the floor. The blinds, picture frames and shelves in the bathroom with angel figurines were observed to be dusty. During an interview and observation on 4/19/2024 at 1:44 P.M., Resident 42 indicated staff had cleaned the bathroom, swept, and mopped the floors, but no one had dusted. The blinds, picture frames and shelves in the bathroom were observed to be dusty. During an interview on 4/22/2024 at 9:54 A.M., Resident 42 indicated no one cleaned her room this weekend, the girls only removed her trash. Today the housekeeper was not in the bathroom long enough to do anything, and the floors had not been swept or mopped. The blinds, picture frames and shelves in the bathroom were observed to be dusty. During an interview on 4/23/2024 at 11:06 A.M., Resident 42 indicated the bathroom was cleaned and dust mopped but was not wet mopped, trash containers were emptied. The blinds, picture		to the extent possible. To have housekeeping and maintenance necessary to maintain a sanitary, orderly and comfortable interior. Housekeeping department deep cleaned every occupied resident room utilizing the Resident Room Cleaning Checklist (Attachment A) All residents residing in the facility have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur all housekeeping staff has been In Serviced on the Resident Room Cleaning Checklist. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC, (Attachment B-1). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

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	frames and bathroom shelves were observed to be dusty. A record review was completed for Resident 42 on 4/18/2024 at 2:38 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, hypertension and major depressive disorder. During an interview on 4/22/2024 at 9:30 A.M., Housekeeper 4 indicated when she cleaned a resident's room, she put cleaner in the toilet bowl, sprayed the sink with TB quat solution and waited 3 minutes, so she collected the trash and put it in her bin. Then she would go back to clean the sink and toilet bowl. Then she sprayed a microfiber with quat and wiped down tables, doorknobs, light switches, the sanitizer dispenser, swept the room with a dust mop, restocked toilet paper and paper towel, then used a wet mop and put a wet floor sign out. She dusted twice a week on Mondays and Fridays, including the blinds, light fixtures, windowsills and bathroom corners. She worked on ICF-2 unit. During an interview on 4/23/2024 at 8:50 A.M., Housekeeper 5 indicated that when she cleaned a resident room, she removed the trash, then cleaned the bathroom, door handles, paper towels, soap, hand sanitizer, swept and mopped the floors. She only dusted a room when a resident discharged, died or switched rooms. She worked on ICF-3 unit. During an interview on 4/23/2024 at 11:08 A.M., the Environmental Supervisor indicated she would expect her staff to clean the resident's room daily. The order was up to them, but included spray the toilet & sink with quat solution and let it set for 3 minutes, check the paper towel and toilet paper,		All systemic changes will be completed by May 20, 2024.	

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	then clean the inside and outside of the toilet, sink, & bedside tables, then sweep and mop and put out a wet floor sign. Once a week they should do a more through clean, check refrigerators and clean all high touch areas. On 4/23/2024 at 11:13 A.M., the Administrator provided a policy titled, "Resident Room Cleaning", undated, and indicated it is the policy currently used by the facility. The policy indicated..." DAILY Procedure: 5) sweep and mop floor. 7) Dust with a clean rag and QUAT spray TV's. 8) Dust with a clean rag and QUAT spray bedside tables. 9) Dust with a clean rag and QUAT spray windowsills. MONTHLY: High dust with a clean rag and QUAT spray the following: Over bed lights, Picture frames on walls, Door's and frame's, Closet's, Curtain rod's, Sprinkler pipes, Switch plates, Closets: Floor's and shelves. Wipe with QUAT spray. Sweep and mop floor....." 3.1-19			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the			

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	allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure an allegation of a resident's missing property was reported immediately or within 2 hours after an allegation was made to the State Survey Agency for 1 of 1 resident reviewed for abuse. (Resident 42) Finding includes: During an interview on 4/17/2024 at 10:51 A.M., Resident 42 indicated she just found out $25.00 was missing from her purse today. The last time she saw it was last Friday, and she had it for about 2 weeks. She has always kept her money in her wallet inside her purse, which was placed in a small area between two dressers. She did not put her money anywhere else. Once a month, activities would order food out from a restaurant and today was gyros. When she went to get her money, it was not there. She planned on telling the Social Services Director and indicated it had happened before. She planned on asking for a lock box from the social worker.	F 0609	F-**609 Reporting of Alleged Violations** It is the policy of Miller's Merry Manor to report all incidents (formally known as unusual occurrences) to the Long-Term Care Division of the Indiana State Department of Health. Missing money was reported to the IDH and police. Investigation completed. No misappropriation was found. Money was replaced and lock box was given to resident. All residents have the potential to be affected by the same deficient practice. No other residents have been affected. To ensure that the deficient	05/20/2024

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	During an interview on 4/19/2024 at 9:43 A.M., the resident indicated she had told the social worker, and he was doing an investigation. He did give her a lock box to keep her money it i, which she now kept in the compartment of her walker and carried the key in her pocket. She had not heard any results of the investigation yet. During an interview on 4/22/2024 at 9:52 A.M., the resident indicated she had not heard how the investigation was going. During an interview on 4/23/2024 at 10:56 A.M., the resident indicated the Administrator came in to talk to her yesterday about the missing money and looked through her purse and drawers. He did not find any money. A police officer had not come to talk to her. A record review was completed for Resident 42 on 4/18/2024 at 2:38 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, hypertension and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 4/10/2024, indicated the resident was cognitively intact. A Progress Notes, dated 4/17/2024, 4/18/2024, 4/19/2024 and 4/22/2024, indicated there was no documentation of the missing money. During an interview on 4/22/2024 at 10:20 A.M., the Social Worker indicated he had a couple of grievances he had been working on. During an interview on 4/22/2024 at 10:22 A.M., the Administrator indicated he had no reportable		practice does not recur the Administrator was in-serviced on the policy titled, Incident Reporting to ISDH (Attachment E). To monitor the corrective actions and ensure the deficient practice will not recur, the Clinical Nurse Consultant/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024	

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	incidents completed since the survey started.. During an interview on 4/22/2024 at 10:28 A.M., the Social Worker presented two grievances: 1) dated 4/17/2024 for missing money for Resident 42 and 2) for two missing sweatshirts for another ressident. He indicated the missing money could possibly be misappropriation, but he had not finished looking for the money, he looked in her purse, drawers and with laundry. It potentially would be reported to state if it was not found, but it probably should have been reported and then a follow-up completed. That is what they normally would do. During an interview on 4/22/2024 at 2:15 P.M., the Administrator indicated he reported the missing money today to IDOH and initiated an investigation since the survey team was asking about it. He was not sure what the policy stated, but it should have reported it within 24-48 hours. On 4/22/2024 at 2:30 P.M., the Administrator provided a policy titled, "Incident Reporting to the ISDH," dated 11/29/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of Miller's Merry Manor to report all incidents (formally known as unusual occurrences) to the Long - Term Care Division of the Indiana State Department of Health. Time frames for reporting: Immediately, but no later than 2 hours - suspicion of a crime with serious bodily injury OR allegation of abuse, Within 24 hours - does not involve abuse and does not result in serious bodily injury. 12. Misappropriation of resident property/exploitation - Examples and not limited to: a. Theft of personal property, such as jewelry....."			

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	3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to ensure a thorough investigation was initiated for an allegation of a resident's missing property for 1 of 1 resident reviewed for abuse. (Resident 42) Finding includes: During an interview on 4/17/2024 at 10:51 A.M., Resident 42 indicated she just found out $25.00 was missing from her purse today. The last time she saw it was last Friday, and she had it for about 2 weeks. She has always kept her money in her wallet inside her purse, which was placed in a small area between two dressers. She did not put her money anywhere else. Once a month, activities would order food out from a restaurant	F 0610	F-**610** **Investigate/Prevent/Correct Alleged Violation** It is the policy of Miller's Merry Manor to complete a full investigation of all incidents to determine the root cause and to implement an appropriate plan to prevent reoccurrence. Missing money was reported to the IDH and police. Investigation completed. No misappropriation was found. Money was replaced and lock box was given to resident.	05/20/2024

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	and today was gyros. When she went to get her money, it was not there. She planned on telling the Social Services Director and indicated it had happened before. She planned on asking for a lock box from the social worker. During an interview on 4/19/2024 at 9:43 A.M., the resident indicated she had told the social worker, and he was doing an investigation. He did give her a lock box to keep her money it i, which she now kept in the compartment of her walker and carried the key in her pocket. She had not heard any results of the investigation yet. During an interview on 4/22/2024 at 9:52 A.M., the resident indicated she had not heard how the investigation was going. During an interview on 4/23/2024 at 10:56 A.M., the resident indicated the Administrator came in to talk to her yesterday about the missing money and looked through her purse and drawers. He did not find any money. A police officer had not come to talk to her. A record review was completed for Resident 42 on 4/18/2024 at 2:38 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, hypertension and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 4/10/2024, indicated the resident was cognitively intact. Progress Notes, dated 4/17/2024, 4/18/2024, 4/19/2024 and 4/22/2024, indicated there was no documentation of the missing money. During an interview on 4/22/2024 at 10:20 A.M.,		All residents have the potential to be affected by the same deficient practice. No other residents have been affected. To ensure that the deficient practice does not recur the Administrator was in-serviced on the policy titled, Incident Reporting to ISDH (Attachment E). To monitor the corrective actions and ensure the deficient practice will not recur, the Clinical Nurse Consultant/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	

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	the Social Worker indicated he had a couple of grievances he had been working on. During an interview on 4/22/2024 at 10:22 A.M., the Administrator indicated that he has had no reportable incidents since the survey team entered the building. During an interview on 4/22/2024 at 10:28 A.M., the Social Worker presented two grievances: 1) dated 4/17/2024 for missing money for Resident 42 and 2) for two missing sweatshirts for another resident. He indicated the missing money could possibly be misappropriation, but he had not finished looking for the money, he looked in her purse, drawers and with laundry. It potentially would be reported to state if it was not found, but it probably should have been reported and then a follow-up completed. That is what they normally would do. He spent about a week doing an investigation and did not ask the resident if a crime was committed. He had not interviewed any other residents to see if they had any missing money. He had not done any investigations except for the grievance paper presented. The Administrator may have done an investigation because he was aware of the missing money. During an interview on 4/22/2024 at 2:15 P.M., the Administrator indicated he reported the missing money today to IDOH, and initiated an investigation since the survey team was asking about it. He just started interviewing alert and oriented residents and talking to staff. He left a message with a detective with the local Police Department to report a suspicion of a crime of missing money. On 4/17/2024 at 11:30 A.M., the Administrator provided a policy titled, "Abuse Prohibition,			

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	Reporting, and Investigation", dated 4/18/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... 4. Miller's Health Systems has policies and procedures in place that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 5. Miller's Health Systems has a policy and procedure in place that all reasonable suspicions of crime according to the Elder Justice act are reported to the Indiana Department of Health and the local law enforcement agency. The "Reporting Reasonable Suspicions of a Crime against a Resident" form located on the ISDH website will be used....." 3.1-28(d)			
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			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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, record review, and interview, the facility failed to update a care plan regarding the use of splints for 1 of 18 residents reviewed for care plans. (Resident 19) Finding includes: A record review for Resident 19 was completed on 4/18/2024 at 1:13 P.M. Diagnoses included, but were not limited to: functional quadriplegia, lobster-claw hand, contracture of muscle right hand, and muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 2/5/2024, indicated upper extremity impairment on both upper extremities. During an observation on 4/18/2024 at 9:27 A.M., Resident 19 was observed to have contracture on both hands, and Resident 19 indicated he wears splints during the nighttime hours. A Physician's Order, dated 2/6/2020, indicated Resident 19 to wear a left palm protector with finger separators during sleeping hours, and indicated Resident 19 to wear a right-handed splint during the night/sleeping hours, dated 4/25/2023. A Care Plan dated 6/2/2020, indicated a splint/brace program with assistance needed for	F 0657	**F-657 Care Plan Timing and Revision** It is the policy of Miller's Merry Manor to assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment process. The splint care plan for Resident 19 was updated to reflect the orders for wearing splint. All residents with orders for splints have the potential to be affected by the same deficient practice. No other residents were affected by this. To ensure that the deficient practice does not recur all nurses will be in-serviced on the policy titled, Care Plan Development and Revision (Attachment F).	05/20/2024

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	application of the brace to bilateral hands due to lobster-claws. An intervention dated 1/6/2021, indicated the left-hand brace on at 8:30 A.M. and off at 11:30 A.M., and on at 6:30 P.M., and off at 9:30 P.M. Other interventions, dated 9/3/2021, indicated a restorative nursing program for the left-hand brace to be applied at 8:30 A.M. and off at 11:30 A.M., and applied at 6:30 P.M. and removed at 9:30 P.M., and on the right hand to place splint/brace at bedtime and remove in the morning. During an interview on 4/23/2024 at 2:34 P.M., the MDS (Minimum Data Set) Coordinator indicated care plans were updated at least quarterly and with any new medication or new change to the resident's status. She indicated any new orders should be reflected in the care plan. A policy was provided on 4/23/2024 at 3:54 P.M. by the Director of Nursing. The policy titled, "Care Plan Development and Review", dated 1/24/2020, indicated, " ...Purpose A. To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment process. To assure that the care plan is communicated effectively to the staff and responsible party ...3. Care Plan Revisions A: Care plans will be revised daily and PRN [as needed] as changes in the resident's condition dictate. Changes include but are not limited to changes int eh Physician orders, diet changes, therapy changes, behavior changes, ADL [activities of daily living] changes, skin changes, etc. [et cetera] ...." 3.1-35(d)(2)(B)		To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024	

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F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Base on observation, interview and record review, the facility failed to ensure staff-directed activities were provided in the evening and on the weekends for 1 of 1 resident reviewed for activities. (Resident 3). This had the potential to affect 52 out of 70 residents residing in the facility. Finding includes: During an interview on 4/17/2024 at 10:02 A.M., Resident 3 indicated the facility had no activities in the evenings or on the weekend. She would like to attend activities in the evening and on the weekends. They only had holiday type activities on the weekend for days like Easter and Christmas. A record review was completed on 4/19/2024 at 2:34 P.M. Diagnoses included, but were not limited to: end stage renal disease, type 2 diabetes, and heart failure. An Activity Care Plan, dated 11/11/2022, indicated that she enjoyed increased socialization, stimulation received through her involvement in group activities. She was a social person and	F 0679	F- 679 Activities meet interest/needs each resident It is the policy of Miller's Merry Manor to provide ongoing programing to support residents in their choice of activities, both facility- sponsored group and individual activities and independent activities to meet their interests of and support the physical, mental, and psychosocial well-being of each resident. All alert and orientated residents were interviewed to find which activities they prefer in the evenings and weekends. Activities calendar was adjusted to support weekend and evening activities both facility lead and individual lead. 3 residents residing in the facility were affected by this deficient	05/20/2024

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	attended most activities. The Activity Calendar, dated April of 2024, indicated the last activity during the week was scheduled at either 1:30 P.M. or 2 P.M. On every other Saturday, April 13 and 27, a church service was scheduled for 10:00 A.M. There were no activities on the schedule for April 6, 7, 14, 20, 21, and 28th for the long-term care and rehab units. There were 2 activities provided in the dementia unit on Sundays. The Activity Calendar, dated March 2024, indicated the last activity during the week was scheduled either 1:30 P.M. or 2 P.M. On every other Saturday, there was a 10:00 A.M. church service on March 2,16, and 30th, and an Easter egg hunt on Saturday the 23rd. There were no activities scheduled on March 3, 9,10,17, 24, or 31. During an interview on 4/22/2024 at 1:27 P.M., the Activity Director (AD) indicated she only had one full time assistant who worked Monday thru Friday and a part time assistant who worked Tuesday, Wednesday, and Thursday. The AD came in on Saturday for the church service and then socialized with the residents, but had no other scheduled activities unless it was a holiday. As far as evening activities, her entire staff were gone by 4:30 P.M. during the week. She had no one to do evening or weekend activities. On 4/22/2024 at 2:30 P.M., the Administrator provided a policy titled, "Activities", dated 10/13/2010, and indicated the policy was the one currently used by the facility. The policy indicated "...A. Evaluate the level of functioning for current population. Using the "levels of Dementia" guide sheet. B. Offer at least 2 activities daily for each of the 3 groups. Some		practice. All residents have the potential to be affected by this deficient practice. To ensure that the deficient practice does not recur the facility will continue to develop an activities calendar with evening and weekend activities. May activity calendar (Attachment C) shows the adjustment made. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC, (Attachment B-1). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	

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	activities may be offered for a specific group, others may appeal to all levels. I. Level 5/-6 (Alert/oriented, typically rehab residents). II. 3/4 (will avoid activities requiring new learning) Provide "no fail" activities - activities they are comfortable doing - no new learning. III. Level 1/2 (these are your lowest functioning - typically the ones who sleep during activities - they need sensory stem)....." 3.1-33(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to notify the physician of blood sugars outside the ordered parameters for 1 of 1 resident reviewed for insulin, and weight changes due to heart failure for 1 of 3 residents reviewed for hospitalization. (Resident 19) Finding includes: During an interview on 4/17/2024 at 10:47 A.M., Resident 19 indicated he had high blood sugar and had been recently hospitalized for muscle problems. A record review for Resident 19 was completed on 4/18/2024 at 2:17 P.M. Diagnoses included, but	F 0684	**F- 684 Quality of Care** It is the policy of Miller's Merry Manor to keep the physician appraised of all condition changes. Physician notification was completed on residents identified. All residents that have ordered parameters for physician notification related to blood sugar levels and weights related to heart failure have the potential to be affected by the same deficient practice. No other residents were affected.	05/20/2024

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	were not limited to: heart failure, diabetes mellitus type 2, chronic kidney disease, atrial fibrillation, and anemia. An Admission Minimum Data Set (MDS) assessment, dated 3/12/2024, indicated Resident 19 received insulin for 7 days during the assessment period, and had heart failure and diabetes mellitus as diagnoses. A Physician's Order dated 3/5/2024, indicated to check the blood sugar as needed for signs and symptoms of hypo/hyperglycemia, and to notify the physician for blood sugars less than 70 and greater than 400. A review of the blood sugar record from 3/7/2024 through 4/17/2024 indicated, Resident 19 had the following blood sugars: - 3/11/2024 7:45 A.M. 62 mg/dL (milligrams per deciliter) - 3/13/2024 6:15 A.M. 51 mg/dL - 3/20/2024 6:31 A.M. 68 mg/dL - 4/13/2024 9:14 P.M. 417 mg/dL A Nurse's Note, dated 3/13/2024 at 6:32 A.M., indicated Resident 19's blood sugar at 5:44 A.M. was 72. Resident 19 was given a snack, and the blood sugar was rechecked at 6:15 A.M. with a reading of 51. Resident 19 was given a Nepro protein drink. A Nurse's Note, dated 3/13/2024 at 6:57 A.M., indicated Resident 19 was able to drink approximately 120 milliliters of Nepro, and asked for 2 small pretzel squares from his personal snacks. Resident 19's blood sugar was now 71. After consuming the pretzel squares, Resident 19 indicated he was feeling less fuzzy.		To ensure that the deficient practice does not recur all Nurses will be in-serviced on the policy titled, Physician & Family notification of condition changes (Attachment G), with emphasis given to ordered parameters. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	

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	A Nurse's Note dated 3/20/2024 at 6:50 A.M., indicated Resident 19 was provided four ounces of orange juice for a blood sugar of 68. A Care Plan, dated 3/5/2024, indicated Resident 19 had diabetes and had the potential for having hyper/hypoglycemia (high and low blood sugars). The goal was to have signs or symptoms of hypo/hyperglycemia. Interventions dated 3/5/2024, indicated to notify the physician of blood sugar readings outside the ordered parameters. On 4/23/2024 at 12:25 P.M., RN 2 reviewed the electronic medical record for notification to the physician for blood sugars outside the ordered range. RN 2 indicated there were no notes for notification to the physician for blood sugars out of range for 3/11/2024, 3/13/2024, 3/20/2024, and 4/13/2024. On 4/8/2024, Resident 19 was readmitted to the facility after being admitted to the hospital on 4/5/2024. An Admission History and Physical, dated 4/5/2024, indicated resident 19 presented to the Emergency Room after being found more lethargic and shorter of breath. The Internal Medicine Hospitalist Discharge Summary, dated 4/8/2024, indicated acute on chronic combined systolic and diastolic congestive heart failure with a discharge recommendation of hospice services. The report indicated Resident 19 had been previously hospitalized for treatment of congestive heart failure. A Physician's Order, dated 4/3/2024, indicated			

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	obtain a daily weight after voiding and before breakfast and medication, with the same clothes done each day. The physician was to be notified for a 2-pound weight gain in one day and a four-pound weight gain in five days. Resident 19's weight indicated the following: - 4/14/2024 8:42 A.M. 143.5 pounds - 4/15/2024 no weight was obtained - 4/16/2024 1:24 P.M. 146.0 - 4/18/2024 10:41 A.M. 148.5 pounds (5-pound weight gain in 5 days) - 4/20/2024 10:58 P.M. 145.5 pounds - 4/21/2024 9:50 A.M. 147.5 pounds (2-pound weight gain in 1 day) A Care Plan, dated 4/1/2024, indicated Resident 19 had heart failure. An intervention included following the heart failure protocol as listed on the medication administration record and treatment administration record. During an interview on 4/23/2024 at 11:14 A.M., RN 2 indicated the physician should have been notified if Resident 19 had a weight gain of two pounds in one day or a four-pound weight gain in 5 days. She indicated Resident 19 did not have notification on 4/16/2024, 4/18/2024, and 4/21/2024. The physician was at the facility on 4/18/2024, but the weight gain was not addressed. During an interview on 4/23/2024 at 11:19 A.M., RN 2 indicated the physician should be notified for a blood sugar less than 70 or greater than 400 for Resident 19. She indicated the documentation should be in the progress notes or in the electronic medication administration record notes. A policy was provided on 4/23/2024 at 3:54 P.M. by the Director of Nursing. The policy was titled,			

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	"Weight Management Program". The Director of Nursing indicated a specific policy was not available for heart failure. A policy was provided on 4/23/2024 at 3:54 P.M. by the Director of Nursing. The policy titled, "Blood Glucose Monitoring", indicated, " ...1. Policy It is the policy of [facility name] to monitor blood glucose per physician's orders and to assess for signs of hypoglycemia or hyperglycemia ...4. Procedure C. Each resident shall have specific physician orders for the following: I. Parameters for physician notification both for high and low readings ...." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the			

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	health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to provide ordered nutritional supplements for a resident with significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 10) Finding includes: During an observation on 4/17/2024 at 10:19 A.M., Resident 10 was observed lying in bed sleeping, and a note on the bedside table indicated to please see the nurse before giving fluids. A record review for Resident 10 was completed on 4/19/2024 at 11:01 A.M. Diagnoses included, but were not limited to: hemiplegia, diabetes mellitus type 2, and dysphagia. A Care Plan, dated 8/1/2019, indicated Resident 10 was at nutritional risk related to a cerebral vascular accident (stroke) and anemia. The interventions included offering replacement foods/beverages if meal consumption was 50 percent less, and monitoring weights and intakes. The weight record indicated on 3/5/2025 at 8:32 A.M., Resident 10's weight was recorded as 154.8 pounds and on 4/8/2024 at 1:06 P.M., her weight was 146.2 pounds. A Nurse's Note, dated 4/8/2024 at 4:03 P.M., indicated the Nurse Practitioner noted the weight loss and gave an order for a Glucerna shake 237 milliliters twice daily. A Progress Note, dated 4/12/2024 at 11:39 A.M., indicated Resident 10 had a 5 percent weight loss in 30 days and a 7.5 percent weight loss in ninety days, and that a Glucerna supplement was added	F 0692	**F-692 Nutrition/Hydration Status Maintenance** It is the policy of Miller's Merry Manor to Immediate action to correct was the review of resident 10 supplement order and plan of care. Supplement changed from glucerna to boost and is being consumed per orders. All residents with commercial supplements have the potential to be affected by the same deficient practice. No other residents were affected. To ensure that the deficient practice does not recur all Nurses will be in-serviced on the policy titled, Nutritional Oral Supplements (Attachment H). To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the	05/20/2024

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	twice daily. The Medication Administration Record for April 2024 indicated Resident 10 did not receive the Glucerna 237 milliliter shake on 4/13/2024 A.M., 4/14/2024 A.M. & P.M., 4/15/2024 P.M., 4/18/2024 P.M., 4/19/2024 P.M., 4/20/2024 P.M., and 4/22/2024 A.M. During an interview on 4/23/2024 12:47 P.M., RN 3 indicated Resident 10 should be receiving the Glucerna shake twice a day. She indicated the shake had not been out of stock, and the resident had not refused the shake for her, and always drinks the entire shake. RN 3 indicated she would notify the physician and/or nurse practitioner if Resident 10 did not receive the shake or she refused to consume the shake. A policy was provided on 4/23/2024 at 3:54 P.M. by the Director of Nursing. The policy titled, "Weight Management Program", indicated, " ...1. Policy All resident's weight status will be monitored by procedure ...G. Resident experiencing unplanned weight change will be assessed for interventions ...J. Programs utilized by the facility may include ...Nutritional Oral Supplements ...." 3.1-46(a)(1)		audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.			

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	155102	A. BUILDING 00 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

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	§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, record review, and interview, the facility failed to provide safe side rails and complete an assessment for 1 of 2 residents reviewed for environment. (Resident 19) Finding includes: During an observation on 04/17/2024 at 9:26 A.M., Resident 19's bed had a side rail in the up position on the left side of the bed when standing at the foot of the bed. The side rail had 3 openings with one opening appearing larger than the recommended dimensions for safety. A record review was completed on 4/18/2024 at 2:17 P.M. Diagnoses included, but were not limited to: bipolar disorder, functional quadriplegia, unspecified dementia, lobster-claw left hand, lack of coordination, contracture of muscle right hand, and delusional disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/5/2024, indicated bed rails were not in use, and Resident 19 had no	F 0700	F-700 Bedrails It is the policy of Miller's Merry Manor to ensure that when bed rails are in use that correct installation, use and maintenance of the bed rails. Facility must access the resident for entrapment from bed rails prior to installation. Maintenance staff reviewed all beds with side rails (April 24, 2024). Result of audit noted 5 beds total were deficient having openings larger than the recommended size. All beds with deficient side rails have been taken out of use and placed in storage and will be scrapped. 5 new beds with appropriate rails have been ordered to replace the deficient beds (Attachment J).	05/20/2024

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	impairment of his extremities. A Physician's Order, dated 4/7/2024, indicated an assistive device of half side rails on both sides of the bed to assist with mobility and safety. A Care Plan, dated 4/7/2024, indicated that Resident 19 had the need for an assistive device of two half side rails to enable Resident 19 to reposition and assist staff while turning in bed. The interventions included completing a bed rail screen on admission, annually, and as needed, and to ensure proper body alignment in bed, and to not be placed too close to either side of the bed rail. A bed rail screen could not be found in the medical record. The Nurse's Note indicated no documentation for the need for side rails. On 4/23/2024 at 1:22 P.M., the Executive Director and the Maintenance Director accompanied the Surveyor to Resident 19's room. The Maintenance Director measured the larger opening of the side rail and indicated it measured 7 inches by 7.5 inches. During an interview on 4/23/2024 at 1:23 P.M., the Executive Director indicated that he did not know the safe measurements for side rails, and these side rails controlled the bed's ability to lift and adjust the head and foot of the bed. He indicated he had been aware that side rails became an issue "a while ago." During an interview on 4/23/2024 at 1:37 P.M., Resident 19 indicated that his arms had been caught in the side rails previously when he had		4 residents residing in the facility were affected by this deficient practice. All residents with siderails have the potential to be affected. All deficiencies have been corrected. Staff in-service will be completed with all staff so they can identify deficient side rails. Facility Nurses will be in-serviced, using the Side Rail Assessment Procedure (Attachment D), on side rail assessment completion and updating. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC, (Attachment B-1 and B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	

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	jerking movements. On 4/23/2024 1:48 P.M., the Director of Nursing and the Clinical Service Coordinator both looked in the chart for a side rail assessment, both indicated they did not see an assessment completed for side rail use. A policy was provided on 4/23/2024 at 3:54 P.M. by the Director of Nursing. The policy titled, "Assistive and Restrictive Devices [Restraint] Use and Application Procedure", indicated, " ...It is the policy of [company name] that assistive devices may be used to enhance the resident's normal functional abilities, improve positioning, increase independence and promote comfort ...Prior to initiation of an assistive device, the licensed nurse will complete an assessment to evaluate the purpose of the device ...." 3.1-45(a)(1)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure it was free of medication error of greater than 5 percent for 3 of 3 residents (Resident 24, 56, and 60) observed during medication pass. Three medication error were observed during 31 opportunities for error in medication administration. This resulted in a medication error rate of 9.68 percent. Findings include: 1. During an observation on 4/22/2024 at 10:48	F 0759	**F-759 Free of Medication Error Rts 5 Percent or More** It is the policy of Miller's Merry Manor to administer insulin according to physician orders. When fast acting insulin is administered a snack or meal will be offered within 15 minutes after administration.	05/20/2024

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	A.M., LPN 7 administered insulin to Resident 56, 8 units of Novolog for a blood sugar result of 313. A record review was completed for Resident 56 on 4/22/2024 at 1:30 P.M. Diagnoses included, but were not limited to: type 2 diabetes. The Physician Order, dated 1/25/2024, indicated Novolog injection solution 100 units/ML (milliliters), inject as per sliding scale: 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350=8 units, 351-400=10 units. Notify MD if blood sugar >400, subcutaneously four times a day for DM 15 min before meal/snack. During an interview on 4/22/2024 at 11:46 A.M., Resident 56 indicated he had not received a snack or his lunch 15 minutes after the insulin injection. He had a plate with a serving of green beans, potatoes and a few bites out of the sandwich. 2. During an observation on 4/22/2024 at 10:57 A.M., LPN 7 administered insulin to Resident 60, 2 units of Flasp for a blood sugar result of 154. A record review was completed for Resident 60 on 4/22/2024 at 1:35 P.M. Diagnoses included, but were not limited to: type 2 diabetes. The Physician Order, dated 3/13/2024, Flasp injection solution 100 units/ML inject per sliding scale: if 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400- 10 units. Subcutaneously three times a day for DM. Give 15 minutes before meal/snack. During an interview on 4/22/2024 at 11:38 A.M., Resident 60 indicated she had not received a snack or her lunch 15 minutes after the insulin injection. She received her meal about 5 minutes		Residents involved where assessed for signs and symptoms of hypoglycemia with none found. All residents with orders for fast acting insulin have the potential to be affected by the same deficient practice. No other residents were affected. To ensure that the deficient practice does not recur all nurses will be in-serviced on fast acting insulin and action times. Fast acting insulin starts working within 15 minutes after injecting and peaks 1-2 hours after injection. When administering fast acting insulin, a snack or meal should be provided within 15 minutes of administering to prevent blood sugar from dropping too low. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality	

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	ago and had a full plate of green beans and potatoes. 3. During an observation on 4/22/2024 at 11:10 A.M., LPN 7 administered insulin to Resident 24, 8 units of Novolin R for a blood sugar of 340. She did not sign off on the electronic medical record that the insulin was administered when she returned to the med cart. A record review was completed for Resident 24 on 4/22/2024 at 1:40 P.M. Diagnoses included, but were not limited to: type 2 diabetes. The Physician Order, dated 2/29/2024, Novolin R injection solution, inject as per sliding scale: if 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units. Subcutaneously three times a day for DM. Give 15 minutes before meal/snack. During an interview on 4/22/2024 at 11:57 A.M., Resident 24 indicated she had not received a snack after getting the insulin. She had a full plate of food in front of her with only bites from the sandwich, a full serving of potatoes, does not like green beans, and small portion of soup consumed. On 4/22/2024 at 9:30 A. M., the LPN 7 indicated she checked blood sugars between 10:30 and 11:00 A.M. During an interview on 4/22/2024 at 12:02 P.M., LPN 7 indicated the time frame she should give insulin was 15 minutes before meals or with a snack. She denied offering a snack to Residents 24, 56 & 60, and indicated the meal did not start until 11:30 A.M. On 4/23/2024 at 1:12 P.M., the Director of Nursing		Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by May 20, 2024.	

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	indicated the facility did not have a policy for following physician orders. 3.1-48(c)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure infection control practices were followed for 2 of 2 residents receiving blood	F 0880	**F- 880 Infection Prevention & Control**	05/20/2024

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	glucose monitoring. (Resident 56 & 60) Findings include: 1. During an observation on 4/22/2024 at 10:42 A.M., LPN 7 checked Resident 56's blood sugar, returned to her cart and cleaned the glucometer with one alcohol prep pad, then set it back down on the medication cart. A record review was completed for Resident 56 on 4/22/2024 at 1:30 P.M. Diagnoses included, but were not limited to: type 2 diabetes. 2. During an observation on 4/22/2024 at 10:54 A.M., LPN 7 proceeded to check Resident 60's blood sugar using the same glucose monitor she had used on Resident 56. LPN 7 cleaned it again with one alcohol prep and proceeded to check the resident's blood sugar. A record review was completed for Resident 60 on 4/22/2024 at 1:35 P.M. Diagnoses included, but were not limited to: type 2 diabetes. During an interview on 4/22/2024 at 10:57 A.M., LPN 7 indicated she did not know what the policy was for the cleaning of the glucometer but would find out. During an interview on 4/22/24 at 11:07 A.M., the Director of Nursing (DON) indicated alcohol prep was not appropriate to use to clean the glucometer. During an interview on 4/22/24 at 1:15 P.M., the DON indicated none of the residents who required use of the glucometer had any communicable disease.		It is the policy of Miller's Merry Manor to clean the glucometer after each use to maintain infection control between resident use. Nurse was verbally educated on proper cleaning of the glucometer. All residents receiving blood sugar checks have the potential to be affected by the same deficient practice. No other residents were affected. To ensure that the deficient practice does not recur all Nurses and QMA's will be in-serviced on the Cleaning of the Glucometer Policy (Attachment I). To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled Annual Survey 4-23-24 POC (Attachment B-2). This tool will be completed 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be	

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	On 4/22/2024 at 11:25 A.M., the Director of Nursing provided a policy titled, "Cleaning of Glucometer", dated 4/23/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...2. A. The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe (Clorox, Lysol, Gulf South etc) and completely wiping down the glucometer so it is visibly wet. Avoid getting the screen wet, as the disinfectant could leak into the internal components and destroy the meter. B. Disinfectant should never be sprayed directly on the machine. Always use a cloth or wipes. C. Follow manufacturer's instructions related to length of time to disinfect before using. Air dry time is typically around 30 seconds, so you must rewet the meter or wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the manufacturer. D. Place wrapped Glucometer in covered container and set timer for manufacturer's contact kill time. E. Once contact kill time has expired, wait and allow to air dry before re-using the glucometer....." 3.1-18(b)		reviewed at the monthly QAPI meeting with changes made as appropriate. . All systemic changes will be completed by May 20, 2024.	