STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a comprehensive care plan for a resident receiving an anticoagulant medication for 1 of 17 sampled residents reviewed for care plans. (Resident 36) Finding includes: Record review for Resident 36 was completed on 3/11/20 at 9:22 a.m. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 2/4/20, indicated the resident received an anticoagulant medication. The Medication Administration Record [REDACTED]. Interview with the MDS Coordinator on 3/12/20 at 9:52 a.m., indicated there was no specific Care Plan regarding the anticoagulant medication and risk for bleeding or bruising. 3.1-35(a)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 27) Finding includes: On 3/10/20 at 10:00 a.m., Resident 27 was observed with areas of reddish/purple discoloration to the top of his right hand. Interview with the resident at the time, indicated he must have bumped his hand. He also indicated he bruised easily. The record for Resident 27 was reviewed on 3/10/20 at 1:49 p.m. [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) assessment, dated 12/6/19, indicated the resident was cognitively intact for daily decision making. A physician's orders [REDACTED]. The weekly skin assessment, dated 3/5/20, indicated the resident had no skin issues. There was no documentation in the Nurses' Notes related to bruising to the right hand. Interview with the Assistant Director of Nursing on 3/12/20 at 11:40 a.m., indicated when a bruise was noted, it was to be monitored for 7 days. Interview with the Director of Nursing on 3/12/20 at 1:30 p.m., indicated the resident was independent and he should have told the staff about the bruise. 3.1-37(a)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure sore received the necessary treatment and services to promote healing, related to the lack of a treatment in place for pressure sores for 1 of 3 residents reviewed for pressure sores. (Resident 212) Finding includes: On 3/11/20 at 9:18 a.m., Resident 212 was observed sitting in a wheelchair in her room. The resident had socks and tennis shoes on both of her feet. The resident indicated she had a wound to both of her heels. On 3/11/20 at 4:00 p.m., LPN 2 was observed to complete wound treatments on Resident 212. CNA 1 assisted the resident into bed and removed the resident's tennis shoes. When the resident's socks were removed, the resident did not have a wound dressing in place to either heel. There was a small, black, area noted to each heel. The LPN then proceeded to complete the resident's wound care and applied a new dressing to each heel. The LPN asked the CNA when the dressings had came off and she was unsure. Interview with the LPN after the treatment, indicated he was unsure if the resident's wound dressings had come off last night or that day. The resident was unable to put on or take off her own shoes and socks. Staff should have let him know when the wound dressings had came off so he could have reapplied them. Record review for Resident 212 was completed on 3/11/20 at 9:32 a.m. [DIAGNOSES REDACTED]. The resident was admitted to the facility on [DATE]. A Facility Brief Interview for Mental Status indicated the resident was cognitively impaired. A Care Plan indicated the resident was admitted with a pressure injury to both heels. The risk factors included: Co-morbid conditions, such as end stage [MEDICAL CONDITIONS] disease, diabetes, cognitive impairment, and impaired/decreased mobility and decreased functional ability. An intervention included to administer treatments as ordered. A Wound Pressure Injury Assessment, dated 3/4/20, indicated the resident had an unstageable wound to the right heel. The wound measured 1.8 cm (centimeters) x 1.2 cm. The wound was 100% eschar (dead tissue). The treatment plan was to apply skin prep (liquid applied to skin that forms a protective film or barrier) and a [MEDICATION NAME] dressing (transparent medical dressing to cover and protect wounds). A Wound Pressure Injury Assessment, dated 3/4/20, indicated the resident had an unstageable wound to the left heel. The wound measured 1.7 cm x 1.6 cm. The wound was 100% eschar. The treatment plan was to apply skin prep and a [MEDICATION NAME] dressing. A physician's orders [REDACTED]. Change once weekly on Wednesday and PRN (when necessary) for wrinkling or dislodgement. A physician's orders [REDACTED]. Change once weekly on Wednesday and PRN for wrinkling or dislodgement. Interview with the Director of Nursing on 3/12/20 at 8:47 a.m., indicated a CNA should have reported to the nurse when the resident's wound dressing had came off so the nurse could have reapplied a new dressing. 3.1-40(a)(2)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure range of motion (ROM) was provided for 1 of 3 residents reviewed for limited ROM. (Resident 50) Finding includes: On 3/10/20 at 10:00 a.m., Resident 50's left hand was observed to be closed in a fist. No splint or anti-contracture device was in place. The record for Resident 50 was reviewed on 3/10/20 at 2:14 p.m. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/20, indicated the resident was moderately impaired for daily decision making and had functional range of motion impairment on one side of his upper and lower extremities. The updated Care Plan, dated 2/20/20, indicated the resident had late loss ADL's (activities of daily living). The resident needed supervision assist with eating/drinking, extensive assist with bed mobility, extensive assist with toileting due to left [MEDICAL CONDITION], dementia and generalized weakness. Interventions included, but were not limited to, passive range of motion (PROM) with ADL's. There was no documentation indicating the resident received PROM with his ADL care. Interview with the Director of Nursing on 3/12/20 at 1:30 p.m., indicated it was expected of the staff to perform PROM with ADL care. Informal restorative care was part of daily care and not documented on the restorative grid. 3.1-42(a)(2)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure nutritional supplement consumption was documented as well as the amount of intake for a resident with a significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 3/11/20 at 7:29 a.m. The resident was admitted to

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the facility on [DATE]. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/20, indicated the resident was cognitively intact and alert and oriented. The resident had no oral problems and received a mechanically altered diet. She weighed 206 pounds and had a significant weight loss. The resident needed limited assistance with one person physical assist for eating. A Care Plan, updated 3/10/20, indicated the resident was at nutritional risk related to a body mass of index of less than 25. The resident has had a weight loss noted this month. A Registered Dietitian (RD) Progress Note, dated 1/17/20, indicated the resident's weight was 211 pounds which was a significant weight loss of 7.8% in 90 days. The residents weights were as followed: 11/4/19 233 pounds 11/12/19 233 pounds 12/4/19 211 pounds 1/2/20 211 pounds 2/4/20 204 pounds 2/12/20 207 pounds 3/3/20 206 pounds physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. The MAR, dated 1/2020, indicated the Glucerna was not signed out as being administered on 1/12, 1/7, 1/24, and 1/25/20. The MAR, dated 2/2020 indicated the Glucerna was not signed out as being administered 2/6, 2/8, 2/12, 2/16, and 2/19/20. The MAR, dated 3/2020 indicated the Glucerna was not signed out as being administered 3/9/20. There was no documentation for the above months of the amount of Glucerna the resident actually drank. Interview with the Director of Nursing on 3/12/20 at 9:30 a.m., indicated the nurses were to be documenting the amount of intake of the Glucerna as well as signing it out when they administered the supplement. 3.1-46(a)(1)
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide appropriate pe[DEVICE] (a tube in the resident's abdomen) services related to medication administration for 1 of 1 pe[DEVICE] medication administration observations. (Resident 23) Finding includes: On 3/10/20 at 1:20 p.m., RN 1 was observed preparing medications for Resident 23. She poured 3 liquid medications into individual clear plastic pill cups then individually crushed 2 white pills and poured the contents into clear plastic pill cups. The nurse then entered the resident's room and proceeded to administer the medications. She administered the medications 1 by 1, however, she did not dilute the 2 crushed medications prior to administration. Interview at the time with the RN indicated the 2 crushed medications should have been diluted prior to administration. Interview with the Director of Nursing (DON) on 3/10/20 at 2:15 p.m., indicated the nurse should have diluted the crushed medications prior to administration The Enteral-Medication Administration policy, dated 4/4/11, provided by the DON on 3/10/20 at 2:12 p.m., indicated .dissolve the powder with water or other recommended liquid in a liquid medication cup . 3.1-44(a)(2)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration flow rate for 1 of 2 sampled residents reviewed for respiratory care. (Resident 36) Finding includes: On 3/9/20 at 9:47 a.m. Resident 36's oxygen was observed in place and infusing via nasal cannula. The resident indicated her oxygen should be set at 3 liters. The oxygen concentrator flow rate was set at 3.5 liters. On 3/12/20 at 9:23 a.m. Resident 36 was observed seated in her wheelchair in her room. Her oxygen was in place and infusing via nasal cannula. The oxygen concentrator flow rate was set at 3.5 liters. Record review for Resident 36 was completed on 3/11/20 at 9:22 a.m. [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. A facility policy, titled Oxygen Administration Protocol, and received as current, indicated .2. Indications: Administration of oxygen, l/pm (liters per minute) and type of delivery system is based on a physician order [REDACTED].
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a hand splint used for pain was on and intact to a resident's wrist for 1 of 1 residents reviewed for pain. (Resident 16) Finding includes: On 3/9/20 at 9:50 a.m., and 12:50 p.m., Resident 16 was observed sitting in a wheelchair in the common/dining area near the nursing station. There was no splint on the resident's right hand. On 3/10/20 at 10:05 a.m., 1:40 p.m., and 3:00 p.m., the resident was observed sitting in a wheelchair in the common/dining area near the nursing station. There was no splint on the resident's right hand. On 3/11/20 at 7:30 am., and 11:20 a.m., the resident was observed sitting in a wheelchair in the common/dining area near the nursing station. There was no splint on the resident's right hand. On 3/12/20 at 8:20 a.m., 8:55 a.m., and 9:15 a.m., the resident was observed sitting in a wheelchair in the common/dining area near the nursing station. There was no splint on the resident's right hand. The record for Resident 16 was reviewed on 3/10/20 at 1:42 p.m. [DIAGNOSES REDACTED]. The Admission Minimum Data Set MDS assessment, dated 1/4/20, indicated the resident was not alert and oriented and had no impairment to either bilateral upper or lower extremities. A Care Plan, dated 2/13/20, indicated the resident was to wear a wrist splint to her right hand. An Occurrence Progress Note, dated 2/13/20, indicated the resident had a fall and was sent to the hospital. She returned with new orders for a wrist splint to the right hand. physician's orders [REDACTED]. The Treatment Administration Record for the month of 3/2020, indicated the wrist splint was signed out as being applied on 3/9, 3/10, 3/11, and 3/12/20 for the day shift. Interview with CNA 1 on 3/12/20 at 8:55 a.m., indicated the resident did not wear a splint to her right hand. Interview with LPN 1 on 3/12/20 at 9:15 a.m., indicated she was unaware if she wore a splint to the right wrist. She walked into the resident's room and looked in all three drawers and did not find the splint. After looking in the closet, it was found under some clothes. 3.1-37(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain an infection control program related to hand hygiene after glove removal during medication pass and during [MEDICAL CONDITION] (trach) care, and incomplete documentation for the infection control program for 1 of 1 residents observed during [MEDICAL CONDITION] care and 1 of 5 residents observed during medication pass. (Residents 23 and 53) Findings include: 1. On 3/11/20 at 6:26 a.m., LPN 3 was observed preparing to do [MEDICAL CONDITION] care for Resident 23. The LPN washed her hands with soap and water and donned a pair of clean gloves. She used a moist towelette and wiped the resident's neck. She removed those gloves and threw them away. The LPN opened the [MEDICAL CONDITION] kit and removed a pair of sterile gloves and donned them to both hands. She did not perform hand hygiene after removing the used gloves. She opened the package of peroxide and the bottle of normal saline and mixed them in the plastic container. With the same pair of sterile gloves, she removed the split gauze sponge and cleaned the stoma and under the flange with a wet gauze sponge and dried them with another gauze sponge. She did not remove her gloves after cleaning the stoma and under the flange. The LPN removed the cap from the [MEDICAL CONDITION] and pulled out the inner cannula and threw it away in the garbage can. Using the same pair of gloves, she cleaned the outer flange and around the trach, opened the new inner cannula package and placed it inside the trach. She did not change her gloves during the entire procedure. After providing [MEDICAL CONDITION] care, she removed the sterile gloves and threw them away and donned a pair of clean gloves to both hands She did not perform any type of hand hygiene after glove removal. The LPN placed a new split gauze sponge under the trach, picked up her supplies, removed her gloves, and washed her hands with soap and water. Interview with LPN 3 on 3/11/20 at 6:40 a.m., indicated she did not perform hand hygiene after glove removal and she did use the same pair gloves for the entire procedure. The record for Resident 23 was reviewed on 3/11/20 at 6:55 a.m. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 1/14/20, indicated the resident was alert and oriented and had a [MEDICAL CONDITION] while a resident. The Care Plan, dated 12/12/14, indicated the resident had a [MEDICAL CONDITION]. The approaches were to provide [MEDICAL CONDITION] care as ordered. physician's orders [REDACTED]. physician's orders [REDACTED]. Interview with the Director of Nursing on 3/11/20 at 6:50 a.m., indicated the nurse should have performed hand hygiene each time after glove removal and changed her gloves after going from clean to dirty to clean again. The current 10/27/2016 Hand Washing and Hand Asepsis policy, provided by the Director of Nursing on 3/11/20 at 6:50 a.m., indicated hand hygiene was to be performed before and after direct resident contact. 2. The Infection Control Program was reviewed on 3/12/20 at 9:48 a.m. The January, February, & March 2020 Infection Surveillance Date Collection Forms included the following: -resident's name -infection type -culture/X-ray results indicated by a check mark -antibiotic name -antibiotic start and stop date -isolation type if any -if the infection met criteria indicated by a yes or no -if admitted with the infection or in house The Infection Control Logs lacked any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER'S MERRY MANOR	**2901 W 37TH AVE HOBART, IN 46342**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) documentation of the resident's signs and symptoms (s/s) of the infections they had been treated for [REDACTED]. She would then look to see if the resident had any labs or X-ray completed to make sure the resident met the criteria for a true infection. She did not include the s/s for any of the resident's infections on the Infection Control Logs. A policy titled, Infection Control Surveillance Program and received as current from the SDC on 3/12/2020, indicated, .2. Procedure E. At the end of each month, the Infection Control Coordinator will collect information contained in the infection assessments, and list this information on the line listing summary sheet . .3. Documenting Surveillance data A. Information on the line/listing form will include . .II. Signs and symptom information 3. On 3/10/20 at 11:15 a.m., LPN 1 was observed preparing to check Resident 53's blood sugar (BS). She gathered her supplies and entered the resident's room. She washed her hands, donned clean gloves, then proceeded to check the resident's BS level. After she obtained the resident's BS result, she removed and discarded the used gloves. The nurse then gathered the used supplies which she had placed on a paper towel on the resident's bedside table and left the room. The used supplies were then discarded into the sharps container on the side of her medication cart. While at the medication cart, she was then observed preparing the resident's insulin. She re-entered the resident's room, washed her hands, donned clean gloves, then she proceeded to administer the medication. The nurse then removed her gloves and left the room. Interview at the time with the nurse indicated she should have washed her hands after she removed her gloves after the resident's blood sugar check. Interview with the Director of Nursing on 3/10/20 at 2:15 p.m., indicated the nurse should have washed her hands after she removed her gloves initially. 3.1-18(b) 3.1-18(l)
F 0921 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a functional, safe and homelike environment related to marred walls, cracked caulking, and dirty floors. (East and West Units) Findings include: During the Environmental Tour on 3/12/20, from 1:20 p.m. through 1:35 p.m. with the Maintenance Director, the following was observed: 1. East Unit a. room [ROOM NUMBER]-2: There was no privacy curtain. There was 1 resident who resided in the room. b. room [ROOM NUMBER]-2: The floor was dirty and scuffed in areas. There were 2 residents who resided in the room. c. room [ROOM NUMBER]-1: The bathroom ceiling vent was dusty and the caulking around the toilet base was cracked. There were 2 residents who resided in the room and shared the bathroom. 2. West Unit a. room [ROOM NUMBER]-2: The wall behind the bed was gouged and the paint was chipped. There were 2 residents who resided in the room. b. room [ROOM NUMBER]-2: The caulking around the bathroom sink was cracked and the sink was pulling away from the wall. There were 2 residents who resided in the room and shared the bathroom. c. room [ROOM NUMBER]-1: There was residue from non skid strips on the floor next to the bed. There were 2 residents who resided in the room. d. room [ROOM NUMBER]-1: There was residue from non skid strips on the floor. There was 1 resident who resided in the room. Interview with Maintenance Director on 3/12/20 at 1:35 p.m., indicated the above was in need of cleaning or repair. 3.1-19(f)