STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155128	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's at Oak Pointe	411 N Wolf Rd Columbia City, IN 46725

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure medications and treatment supplies were secured, insulin was dated upon opening and discarded upon expiration for 4 of 11 reviewed (Resident 15, Resident 27, Resident 45, and Resident 1). Findings include: 1) During an observation on [DATE] at 9:20 AM, Resident 15 was seated in a recliner in her room with a cup containing 11 round pills of various colors in her hand, and an additional cup with a large oblong pill was observed on her bedside table within her reach. No staff member was in the room or in the hall in the line of vision of Resident 15. Resident 15 indicated she took some of her pills and was going to let the rest of them sit for a little while before she took them. She indicated nurses would normally leave her pills with her to take when she was ready. During an interview, on [DATE] at 9:29 AM, Licensed Practical Nurse (LPN) 6 indicated she left the pills with Resident 15 and intended to come back to make sure she had taken them. Resident 15's record was reviewed on [DATE] at 10:36 AM. Diagnoses included dissociative and conversion disorder, diabetes mellitus type 2, and dementia, unspecified severity with anxiety. Resident 15's current quarterly, Minimum Data Set (MDS), dated [DATE] indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). Resident 15's current care plan titled behavior . indicated the resident had a problem of excessive nervousness, worrying about things she could not control, with a goal date of [DATE]. Interventions included administering medications as ordered. Resident 15's current care plan titled hyperthyroidism . indicated the resident had a problem of a risk for complications, with a goal date of [DATE]. Interventions included administering medications as ordered. During an interview, on [DATE] at 2:04 PM, The Director of Nursing (DON) indicated nurses should watch residents swallow their medications and should not leave pills at the bedside. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled Medication Administration Procedure, dated [DATE], provided by the Administrator on [DATE] at 1:55 PM, indicated staff should remain with the resident until each medication is swallowed. Staff should never leave medication with the resident. 2) During an observation, on [DATE] at 9:18 AM, a labeled bottle of rubbing alcohol, about ,d+[DATE] full of clear liquid, was observed at Resident 27's bedside table, visible from the hallway. During an interview, on [DATE] at 9:30 AM, LPN 6 indicated she was not aware the bottle of rubbing alcohol was at her bedside before this encounter. She indicated there was not a current physician's order regarding Resident 27's use of the alochol. She indicated the Nurse Practitioner should evaluate the appropriateness of the use of rubbing alcohol and provide an order with guidelines for use. She indicated the label indicated the liquid was rubbing alcohol and the amount on the label was 32 ounces. She indicated about ,d+[DATE] of the bottle was empty. During an interview, on [DATE] at 9:29 AM, Resident 15 indicated her family brought the bottle of rubbing alcohol and she used it to cleanse her chin. She indicated she always kept the bottle on her table. Resident 27's record was reviewed on [DATE] at 10:49 AM. Diagnoses included cerebral infarction, chronic kidney disease stage 3, and dysphagia, oral phase. Resident 27's current quarterly Minimum Data Set (MDS) dated [DATE] indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). No physician orders for the use of rubbing alcohol for Resident 27 were available for review. In an interview, on [DATE] at 2:04 PM, the DON indicated the bottle of rubbing alcohol should not have been at the bedside due to risk of accidental consumption. A current policy dated [DATE], titled Storage of Medications provided by DON on [DATE] at 9:54 AM indicated potentially harmful substances should be clearly identified and stored in a locked area separately from medications. 3) During an observation, on [DATE] at 10:51 AM, LPN 5 removed a bottle of lispro insulin from the 100-hall medication cart labeled for Resident 45. The bottle's seal was removed and the top of the rubber stopper had pinprick sized puncture marks. No open date was indicated on the bottle. During an interview, on [DATE] at 10:52 AM, LPN 5 indicated staff should discard the insulin by the expiration date printed on the bottle, or 28 days after opening. She indicated the open date could not be determined because no date was written on the bottle. Resident 45's record was reviewed on [DATE] at 9:20 AM. Diagnoses included type 2 diabetes mellitus with hyperglycemia, hyperlipidemia, and acute on chronic congestive heart failure. Resident 45's current quarterly MDS indicated his BIMS score was 13 (cognitively intact). The MDS indicated Resident 45 used insulin 7 days a week. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Current physician orders dated [DATE] indicated Resident 45 should receive Insulin Lispro solution as per a sliding scale. A review of Resident 45's medication administration record, dated [DATE], indicated Resident 45 was administered Lispro insulin each day from [DATE] through [DATE]. During an interview, on [DATE] at 9:54 AM, the DON indicated insulin bottles should be labeled with an open date and discarded 28 days after opening. A current, undated policy, titled Refrigerated Preparations-Injectables and Liquids, provided by the DON on [DATE] at 9:54 AM, indicated insulin vials should be marked with an open date on the label. 4) During an observation on [DATE] at 8:58 AM, a bottle of Lantus insulin labeled for Resident 1 was labeled with an open date of [DATE]. During an interview on [DATE] at 8:59 AM, Registered Nurse (RN) 7 indicated insulin can be used for 28 days after opening. He indicated the insulin should have been discarded the previous day. He indicated the expired insulin had been administered to Resident 1 earlier that morning. Resident 1's record was reviewed on [DATE] at 2:21 PM. Diagnoses included diabetes mellitus without complications, hyperlipidemia and hypertension. A current admission MDS dated [DATE] indicated Resident 1's BIMS score was 9 (cognitively impaired). The MDS indicated Resident 1 used insulin 7 days a week. Current physician's orders dated [DATE] indicated Resident 1 should receive 13 units of Lantus Insulin twice daily for diabetes mellitus. Resident 1's medication administration record, dated [DATE], indicated Resident 1 was administered 13 units of Lantus insulin on [DATE]. During an interview, on [DATE] at 9:54 AM, the DON indicated insulin bottles should be labeled with an open date and discarded 28 days after opening. A current policy, undated, titled Refrigerated Preparations-Injectables and Liquids, provided by the DON on [DATE] at 9:54 AM, indicated Lantus insulin vials should be marked with an open date on the label and discarded 28 days after opening. 3XXX,d+[DATE](j)(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29081 Based on observation, interview, and record review, the facility failed to ensure left overs were labeled, equipment was cleaned, gloving, and hand hygiene was observed during tray pass. 52 of 52 residents ate food prepared in the kitchen and were served ice from the ice machine. Findings include: 1. During a tour of the kitchen, on 11/12/24 at 09:23 AM, Dietary Manager (DM) 3 indicated the left over chicken patties should be kept 3-7 days. The date on the bag was unreadable. In an interview, on 11/12/24 at 09:23 AM, DM 3 indicated the date on the patties in the gallon zip lock was unreadable. She indicated staff should ensure dates are readable on leftover items. A policy, titled Food Protection and Storage, dated 10/06/2015 indicated X. Food not in original containers are clearly labeled for contents, dated, and stored in food related containers with tight fitting lids. 2. During a tour of the clean utility, on 11/12/24 at 10:39 AM , a black residue was observed on the inside white shield of the ice machine. During an interview, on 11/12/24 at 10:39 AM , Licensed Practical Nurse (LPN) 1 indicated she was not sure what the black residue was on the inside white shield of the ice machine, but she would ask maintenance. During an interview, on 11/12/24 at 10:47 AM, Maintenance 2 indicated the ice machine was cleaned in December and June, according to policy. During an observation, on 11/12/24 at 10:47 AM, Maintenance 2 rubbed off the black residue from the white shield inside the ice machine. Maintenance 2 indicated the ice machine served all residents currently residing in the facility. A policy, titled Ice Machine Monthly Maintenance, provided by Maintenance 2 on 11/12/24 at 10:52 AM, indicated to complete maintenance on the machine monthly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation, on 11/12/24 at 10:59 AM, Dietary Aide (DA) 4 was observed, during pureed meat preparation, to don a glove on his right hand. No hand hygiene had been performed prior to donning the glove. Dietary Aide 4 then touched a bread sack with the gloved hand, put his gloved hand on the menu, handled the beef stock canister, and opened the oven. Without changing the glove, DA 4 completed the pureed meat preparation utilizing the food processor, then placed the pureed meat on the steam table. DA 4 had not changed the glove nor performed hand hygiene. DA 4 then prepared to plate foods for the lunch meal. He did not perform hand hygiene, nor change the glove. DA 4 touched a cart with the gloved hand, then touched serving tongs, then touched the utensil drawer. DA 4 obtained measuring spoons, but had not performed hand hygiene or changed his glove. DA 4 handled measuring spoons with his gloved hand, touched his ungloved left hand, handled a coffee cup with his gloved hand, and stirred the meat puree with a spoon. Dietary Aide 4 removed his glove. With his bare right hand, DA 4 obtained some leftover puree in the food processor by touching the inside of the processor with his ungloved right index finger, then licked his finger. Dietary Aide 4 did not wash his hands prior to regloving for food plating. In an interview, on 11/12/24 at 11:25 AM, DM 3 indicated she knew there were problems with gloving and hand hygiene she would need to correct. A policy, titled Handwashing, dated 10/6/2015 indicated Hand hygiene should be performed G. during food preparation as often as necessary .to prevent cross contamination while changing tasks A policy, titled Glove policy, dated 9/9/2015 indicated when using gloves, they should be used for one task then changed. 3.1-21(i)(1) 3.1-21(i)(3)