| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155173 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Miller's Merry Manor | 505 N Bradner Ave<br>Marion, IN 46952 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>48384<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's urinary catheter was handled in a manner to support the resident's dignity when the drainage bag was left in the view of sight of others within the facility. (Resident 68)<br><br>Findings include:<br><br>During an observation on 11/1/24 at 10:11 a.m., Resident 68's was in bed, with the catheter bag hanging on the right side of the bed frame. The bag was exposed and urine could be seen in the bag.<br><br>During an observation on 11/6/24 at 9:47 a.m., the resident was in bed, with the urinary catheter bag hanging on the right side of the bed frame. The bag was exposed and urine could be seen in the bag.<br><br>Resident 68's clinical record was reviewed on 11/6/24 at 10:50 a.m. Physician orders, dated 5/15/24, indicated catheter care should be performed every shift. The catheter drainage bag was to be below the waist and covered every shift.<br><br>During a catheter care observation on 11/7/24 at 10:16 a.m., RN 3 indicated there was a device on the left side of the resident's bed, on the railing, which contained the catheter bag and served as a covering for the bag. The left side of the bed was against the wall. The RN was not sure why a similar device was not in place on the right side of the bed. The right side of the bed was visible to the rest of the room and from the hallway.<br><br>A current facility policy, titled Foley Catheter Care & Maintenance, provided by the Administrator on 11/7/24 at 10:40 a.m., indicated the following: Placement of Catheter Tubing Procedure: 1) When in bed or wheel chair .b)Place in a catheter cover bag underneath wheelchair or on side of bed<br><br>During an interview with the Infection Preventionist on 11/7/24 at 11:18 a.m., they indicated all catheter bags should be placed in dignity bags when residents are both in or out of their room(s).<br><br>3.1-3(a) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>09676<br><br>Based on observation, interview, and record review, the facility failed to serve a therapeutic pureed diet as ordered by a physician for 2 of 2 residents reviewed who received pureed diets ( Residents 42 and 43).<br><br>Findings include:<br><br>During a lunch meal observation on 11/4/24 from 11:20 a.m. to 11:47 a.m., a regular gelatin dessert with whipped topping was served to Residents 42 and 43. The gelatin was cubed in shape and topped with whipped cream. The cubes were solid pieces of gelatin. Both Residents 42 and 43 consumed a portion of the regular gelatin.<br><br>During an observation on 11/4/24 at 11:50 a.m., Resident 43's meal ticket indicated gravy to meat and potatoes. Resident 43's meat and potatoes contained no gravy, nor was there gravy provided for a staff member to use for topping the food.<br><br>A current facility lunch meal, portion size and texture serving guide (also known as a spread sheet), dated 11/4/24 and provided by the Administrator on 11/7/24 at 10:50 a.m., indicated residents who had pureed diet orders were menued to receive a 1/2 (#8 scoop) of pureed gelatin topped with whipped topping.<br><br>The current facility recipe for pureed diet gelatin, dated 11/4/24 and provided by the Dietary Manager on 11/4/24 at 12:03 p.m., indicated cubed gelatin was to be placed in a blender or food processor and blended until smooth, then topped with whipped topping. The recipe for gelatin contained a standard package of gelatin and hot water.<br><br>During an interview on 1/4/24 at 11:51 a.m., QMA 6 indicated she was not aware of Resident 43's menu card directing the use of gravy on meat and potatoes.<br><br>During an interview, 11/04/24 at 12:06 p.m., QMA 6 indicated the dietary department never provided gravy. During the meal, the resident had eaten both items without gravy.<br><br>During an interview on 11/4/24 at 12:04 p.m., the Dietary Manager indicated she had not realized the gelatin was menued to be pureed prior to service.<br><br>1. Resident 42's clinical record was reviewed on 11/04/24 at 2:18 p.m. Current diagnoses included vascular dementia, anxiety, and dysphasia- oropharyngeal phase. The resident had a current order for a pureed diet, dated 7/9/24.<br><br>The resident had a current care plan problem/need regarding, nutritional risk due to related to a therapeutic diet, mechanically altered diet, a diagnosis of dysphasia, and a history of weight loss. This care plan problem originated 1/19/24. An approach to this problem was to serve a diet as ordered, dated 1/31/20.<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The resident's most recent speech therapy note for services from the period of 7/3/24 to 7/15/24 indicated the resident required a pureed diet due to a diagnosis of dysphasia.<br><br>2. Resident 43's clinical record was reviewed on 11/04/24 at 3:20 p.m. Current diagnoses included dementia, depression, and anxiety. The resident had a current order for a pureed diet served with extra butter, sauce, gravy for potatoes and meats, dated 1/15/24.<br><br>The resident had a current care plan problem/need regarding, nutritional risk related to: mechanically altered diet, end stage illness/condition, and on hospice care, dated 2019. An approach to this problem/need was diet is served as ordered.<br><br>The resident's most recent speech therapy note for services from the period of 1/15/24 to 1/29/24 indicated the resident required a pureed diet due to a diagnosis of dysphasia. The resident received treatment due to pneumonia related to inhalation of food and vomiting.<br><br>A current, 11/23/2011, policy titled, Dietary Manual- Subject -Food Production Services, provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following: 2. Food is chopped, cut, ground and pureed to meet individual resident needs. Procedures to alter food texture are listed on the recipes .4. Food is served by following the therapeutic diet spreadsheets and is portioned by weighing and by using the correct serving utensils .<br><br>A current, undated, facility policy titled, Diets Available In This Facility,provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following: Pureed, Regular diet with food pureed to a smooth pudding-like consistency. For those who have considerable problems chewing or swallowing .<br><br>3.1-21(b) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>09676<br><br>Based on observation, interview, and record review, the facility failed to ensure food was served under sanitary methods regarding food handling, hand washing, and glove use. This deficient practice had the potential to impact 73 of 73 residents who received meals in the facility.<br><br>Findings include:<br><br>1. A completed Roster Matrix form, provided by the facility on 10/30/24 following the entrance conference, indicated the facility had no residents who received nutrition by any alternate means other than oral eating.<br><br>During a lunch meal service observation on 11/4/23 from 11:40 a.m. to 12:03 p.m., the following concerns regarding sanitary food preparation and distribution were made:<br><br>Cook 5 wore gloves. She touched the outside of meal trays, thermal plate bases, heated tray pallets, bread bags, bread rolls, and cheese with her gloved hands. She did not change her gloved hands as she touched the various items. She used her solid gloved hands to open the bread rolls and placed cheese slices inside the roll. Using the same gloved hands, she handed the prepped roll to [NAME] 4, who took the roll with her gloved hands. [NAME] 5 did not change her gloves during this process.<br><br>Cook 4 received prepared bread rolls and cheese with her gloved hands. She used her gloved hands and touched meal tickets, trays, plates, thermal bases. thermal lids, heated pallets, countertops, bread bags, bread rolls, and cheese. At no time during the meal service did she change her soiled gloves.<br><br>Cook 5 left the kitchen wearing her soiled gloves. As she returned to the kitchen, she touched the door and the door knob. She was no longer wearing gloves. She took gloves from the glove box and placed said gloves on her hands. She did not wash her hands prior to applying the gloves.<br><br>2. During a dining observation of the memory care unit, on 11/4/24 at 12:00 p.m., residents were being served Philly cheese steak sandwiches on buns.<br><br>At approximately 12:11 p.m., CNA 4 was observed taking trays from the food cart and delivering them to residents already seated at dining tables. The CNA delivered three trays to various residents. For each of the three residents, the CNA was observed to uncover their plates, offer ketchup to each, then proceeded to open the ketchup packets and squeeze the contents onto each resident's sandwich. The next resident to be served asked the CNA to cut the sandwich. The CNA proceeded to place her bare left hand on the bun, gripped it to secure it, and then used the resident's knife to cut the sandwich into halves. The CNA did not complete hand hygiene during the observation.<br><br>During an interview on 11/4/24 at 12:03 p.m., the Dietary Manager indicated food should not be touched with gloved hands and hands should be washed before gloves were applied.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A current, 10/6/15, policy titled Dietary Manual: Subject: Hand Washing, provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following .It is policy that all dietary employees know and understand when hand washing is required and how to properly wash their hands .F) After handling soiled surfaces, equipment or utensils .G) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks<br><br>A current 9/9/15, facility policy titled, Dietary Manual: Subject: Glove Policy, provided by the Administrator on 11/7/24 at 10:50 a.m., indicated the following: .It is the policy that gloves use will be limited use glove and will be used for only one task. Hands will be properly washed before and after glove use .Procedure: 1) a. Whenever possible use utensils such as tongs, spoons and spatula instead of gloves to avoid getting the false sense of security with the gloves and over using gloves 4) d. If using gloves, hands must be properly washed before and after glove use .When making bread and butter and a new loaf needs to be opened, gloves must be removed, hands properly washed. Open new loaf of bread, then properly wash hands and don a new pair of gloves.<br><br>3.1-21(i)(1) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>48384<br><br>A. Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed according to facility policy and physician orders during wound care for 1 of 1 residents reviewed for wounds. (Resident 23)<br><br>B. Based on observation and interview, the facility failed to ensure staff administered medications in a sanitary manner for 1 of 2 residents observed for medication administration. (Resident 20)<br><br>Findings include:<br><br>A. Resident 23's clinical record was reviewed on 11/6/24 at 3:02 p.m. Diagnoses included acute diastolic (congestive) heart failure, (other) abnormalities of gait and mobility, Type 2 diabetes mellitus with diabetic neuropathy, morbid (severe) obesity due to excess calories, unspecified fracture of left femur, and difficulty in walking.<br><br>Current physician orders included (9/9/24) apply povidone iodine to left heel every shift for wound care, (6/7/24) skin protectant to right heel for skin protection, and (6/4/24) EBP during high-contact resident care.<br><br>A current care plan, dated 6/4/24, indicated the resident required EBP during high-contact care due to antibiotic resistant bacteria in their urine and current wounds. Personal protective equipment (PPE) was to be accessible for use. A sign was to be placed on the door of the resident's room to communicate EBP to staff and visitors.<br><br>During a review of progress notes on 11/7/24 at 9:36 a.m., a note from 11/4/24 at 11:01 am. indicated the pressure injury had a length of 1.0 centimeter (cm) and a width of 1.5 cm.<br><br>During an observation on 11/7/24 at 10:05 a.m., RN 3 performed wound care to the left heel for Resident 23. Supplies were brought into the room and the nurse performed hand hygiene, donned gloves, and cleaned the pressure area with soap and water, dried the area, and applied povidone iodine (a topical antiseptic to prevent infections) to the left heel wound. The wound was approximately the size of a quarter and dark red in appearance. The nurse replaced the resident's sheet and blanket and disposed of used supplies at that time.<br><br>During an interview with RN 3 on 11/7/24 at 10:35 a.m., she indicated a gown was not required for wound care. She was aware of the EBP ordered for the resident. Gowns were required only when performing peri-care (care of the genital area).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A current facility policy, dated 4/6/24, titled Enhanced Precautions for Novel and Targeted MDRO's (multidrug resistant organisms) and provided by the Infection Preventionist on 11/7/24 at 10:10 a.m., indicated the following: Policy - To prevent the spread of multidrug resistant organisms (MDRO's) from one resident to another resident via health care workers hands and clothing and to protect vulnerable residents. The use of EBP is intended to interrupt the spread of novel or targeted MDRO's . EBP is targeted use of gown and glove use during high contact resident care activities for residents with wounds and indwelling devices .Procedure - Residents with wounds or indwelling devices and residents infected or colonized with an MDRO will be cared for by staff using a gown and gloves during high contact resident care .Examples of high contact resident care include, but are not limited to .8) performing wound care (caring for an opening in the skin .that is long lasting or chronic in nature such as pressure ulcers, diabetic wounds, non-healing surgical wounds, and chronic vascular ulcers<br><br>During an interview with the Infection Preventionist on 11/7/24 at 11:28 a.m., the IP indicated wound care required PPE including gloves and gowns for wound care. In the case of Resident 23, the staff should gown and glove during wound care on the left heel.<br><br>B. During a medication administration observation, on 11/6/24 at 9:22 a.m., Qualified Medication Aide (QMA) 7 prepared and administered oral medications for Resident 20. She then administered lubricant eye drops in each eye by using her bare left hand to lift each eye lid. The QMA did not perform hand hygiene, nor don gloves, before administering the eye drops.<br><br>During an interview, on 11/6/24 at 9:42 a.m., QMA 7 indicated it was not her practice to don gloves prior to administering eye drops and was unsure if there was a facility policy pertaining to eye drop administration.<br><br>A current facility policy, titled Eye Drops and Eye Ointment Procedure, provided by the Administrator on 11/6/24 at 11:16 a.m., indicated 16) Perform hand hygiene and put on gloves During an interview at the same time the policy was provided, the Administrator indicated it was the expectation of the facility that QMA 7 should be aware of this policy.<br><br>3.1-18(l) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146<br><br>Based on record review and interview, the facility failed to ensure pneumococcal vaccination (to protect against the bacterium Streptococcus pneumoniae) was offered or administered for 3 of 5 residents reviewed for immunizations. (Residents 32, 53, and 14)<br><br>Findings include:<br><br>1. Resident 32's clinical record was reviewed on 11/4/24 at 11:40 a.m. Diagnoses included left-side non-dominant hemiplegia and hemiparesis following cerebrovascular disease, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus. The resident admitted in 2020.<br><br>Resident 32's immunization record indicated an undated refusal for the pneumococcal 13-valent conjugate vaccine (PCV 13) and pneumococcal polysaccharide vaccine (PPSV 23).<br><br>A Pneumococcal/Prevnar 13 Vaccine Consent form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident had refused the above vaccines on 2/28/20.<br><br>During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she discussed the importance of vaccines during care plan meetings, but was not able to provide additional documentation for consent or refusal following 2020, including in 2024.<br><br>2. Resident 53's clinical record was reviewed on 11/4/24 at 2:17 p.m. Diagnoses included orthopedic aftercare following surgical amputation, heart failure, and diabetes mellitus due to the underlying condition of hyperglycemia. The admitted was 4/19/24.<br><br>Resident 53's immunization record indicated an undated refusal for the Pneumococcal 20-valent conjugate vaccine (Prevnar 20) and a entry marked as pending for the Prevnar 20 vaccination.<br><br>A Pneumococcal Vaccine Consent form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident wished to receive the recommended pneumococcal vaccine based upon vaccination history.<br><br>During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she was not able to explain the marked refusal or confirm if the resident had received the appropriate vaccination.<br><br>3. Resident 14's clinical record was reviewed on 11/6/24 at 11:47 a.m. Diagnoses included Alzheimer's Disease, COPD, and generalized anxiety disorder. The resident admitted in 2019.<br><br>Resident 14's immunization record indicated an undated refusal for the PCV 13 vaccination.<br><br>A Pneumococcal/Prevnar 13 Vaccine Consent form, provided by the Infection Preventionist on 11/7/24 at 11:09 a.m., indicated the resident had refused the PCV 13 on 3/25/19.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 11/7/24 at 11:09 a.m., the Infection Preventionist indicated she discussed the importance of vaccines during care plan meetings, but was not able to provide additional documentation for consents or refusals in the years following 2019, including 2024.<br><br>During a follow-up interview, on 11/7/24 at 12:10 p.m., the Infection Preventionist indicated she contacted residents and families yearly, starting in August, to discuss the current flu vaccinations and pneumococcal vaccines for each resident. She verified the residents' vaccinations in the clinical record and on the Children and [NAME] Immunization Registry Program (CHIRP). The pharmacy and physician determined the appropriate vaccination for each resident. The IP utilized the consent form, which had an option to decline the vaccine. The consent forms were uploaded to the medical record as soon as possible.<br><br>A current facility policy, dated 7/6/15, titled Influenza and Pneumococcal Immunization Program, and provided by the Administrator on 10/30/24 following the entrance conference, indicated the following: .It is the policy of Miller's Health Systems to administer annual Influenza and Pneumococcal vaccines, as recommended by APIC and the CDC, to all residents residing in the facility . The facility will administer immunizations in accordance with recommendations established by the Centers of Disease Control and Prevention in effect at the time the immunizations are administered .<br><br>A current facility policy, dated 10/11/22, titled Pneumococcal Disease Immunization Procedure, and provided by the Infection Preventionist on 11/7/24 at 2:17 p.m., indicated the following: .Pneumococcal vaccines PPSV 23 (Pneumococcal Polysaccharide vaccine) and PCV 15 and PCV 20 (Pneumococcal conjugate vaccines) will be offered, encouraged, and provided to all residents residing in the facility. The vaccine will be administered according to the Center for Disease Control and Prevention recommendations .<br><br>3.1-13(a) |