

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Miller's Merry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 26th St Logansport, IN 46947	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44531</p> <p>Based on observation, interview, and record review. The facility failed to ensure n elopement alarm was followed for 1 of 1 resident reviewed. Resident 77</p> <p>Finding include:</p> <p>A record review began on 3/19/24 at 1:07 P.M. Resident 77 diagnosis include unspecified intracranial injury with loss of consciousness of status.</p> <p>A review of the Minimum data Section dated 3/6/23, indicated a wander/elopement alarm was used daily. A brief interview for mental status (BIMS) is a 13 from 15. This indicated the resident was able to interact appropriately.</p> <p>A physician order dated 12/13/23 indicated to check wander guard function daily, placed on wheelchair everyday.</p> <p>A care plan titled risk for elopement indicated interventions included wander guard sensor bracelet to be applied.</p> <p>A review of nursing-supplemental elopement risk assessment dated [DATE] indicated Resident 77 was not at risk for elopement. There was no need for wander guard bracelet to be applied. The care plan and physician orders had not been updated to reflect this change.</p> <p>A record review of the Treatment Administration Record (TAR) dated January, February, and March 2024 indicated:</p> <p>Dated January 2024 on day shift: the wander guard check function daily-place on wheelchair was checked as being on the wheelchair the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24,25, 26, 27, 28, 29, 30, and 31.</p> <p>Dated February 2024 on day shift: the wander guard check function daily-place on wheelchair was check-off for the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>For the month of March on day shift: the wander guard check function daily-place on wheelchair was check-off for the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21.</p> <p>An observation on 03/20/24 at 9:57 A.M. Resident 77 was in room in wheelchair on the lower side is a small band (wander guard) was visible.</p> <p>In an interview on 3/21/24 at 9:45 AM, the Director of Nursing indicated, Resident 77 was re-evaluated and it was decided he did not need the wander guard anymore. So, it should have been removed from the wheelchair and physician orders on 1/5/24.</p> <p>A current facility policy, Elopement Risk Assessment, dated 6/3/14, was provided by the Administrator on 3/19/24 at 10:56 A.M. The policy indicated . to assess residents for potential elopement. To assure they are always free from harm</p> <p>3.1-37</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>45243</p> <p>Based on interview and record review the facility failed to ensure personalized trauma informed care for 1 of 1 resident reviewed. (Resident 72)</p> <p>Findings include:</p> <p>Resident 72's record was reviewed on 3/20/24 at 9:53AM. His diagnoses included dementia, post-traumatic stress disorder (PTSD), depression, and anxiety.</p> <p>Resident 72's comprehensive quarterly Minimum Data Set (MDS) assessment completed 2/28/24 section C for cognitive functioning indicated his BIMS (Brief Interview of Mental Status) score was 7. A score of 7 indicated moderate cognitive impairment.</p> <p>Resident 72's care plan did not include any focus, goal, interventions, or triggers for PTSD. The behavior focused care plan included anxiety and yelling out. The interventions were as follows:</p> <p>Administer psych medication as ordered.</p> <p>Monitor medication side effects at least daily.</p> <p>Notify physician as needed.</p> <p>Listen to concerns and follow-up on these promptly as needed.</p> <p>SS (social services) to visit as needed.</p> <p>Psych services to follow resident as needed.</p> <p>Document mood behavior; yells out increased anxiety.</p> <p>Trauma screenings completed 11/27/23 and 2/28/24 both indicated Resident 72 stated he was well pleased and denied any trauma. The items listed as experiences or history for trauma included: domestic violence, physical abuse, verbal abuse, childhood abuse and neglect, witnessing abuse, and violent death of a loved one.</p> <p>A psychotropic med quarterly review completed 3/10/24 indicated Resident 72 over the prior 90 days had 4 episodes of anxiety during the day, 64 episodes in the evening, and 12 at night with varying effectiveness of interventions used.</p> <p>On 3/20/24 at 9:57AM in an interview, CNA 2 (Certified Nurse Assistant) and the unit manager indicated Resident 72 would get worked up and more anxious in the evening when alone. She indicated she did not know Resident 72 had PTSD or any triggers to watch for. During the interview, the unit manager indicated she was unaware of any triggers and would need to refer to the CNA's pocket care sheets.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The pocket care sheet indicated Resident 72's specific care instructions included diet sensitivities, incontinence, glasses, hard of hearing, and the use of a walker. There were no instructions regarding behaviors or triggers for PTSD on the CNA care sheet tool.</p> <p>During a phone interview on 3/20/24 at 2:30PM, Resident 72's son, POA (Power of Attorney) indicated his father had several traumatic experiences. The POA indicated Resident 72 did not talk about his time in the Navy or any of his military experiences. The POA indicated his father grew up in an extremely physically and emotionally abusive home. Resident 72's bother was shot and killed by their father. According to the POA Resident 72 and his siblings all refused to openly discuss the abusive environment they grew up in, simply stating it was a nightmare. The only trigger the POA was certain of was any talk of Resident 72's parents.</p> <p>A policy titled, Trauma Informed Care, dated 1/18/23, was provided by the administrator 3/20/24 at 2:01PM. The policy indicated, a resident with PTSD will receive person-centered and individualized treatment and services to meet their assessed needs. 6 Any resident diagnosed with PTSD requires collaboration with a metal health provider to develop and implement a person-centered, individualized plan of care.</p>		