

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Miller's Merry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N County Road 825 E Hope, IN 47246	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>34232</p> <p>Based on interview, observation, and record review, the facility failed to provide scheduled ADL (Activities of Daily Living) care related to bathing for 3 of 12 residents reviewed. (Residents 4, 15, and 37)</p> <p>Findings include:</p> <p>1. During an interview on 07/08/24 at 10:22 A.M., Resident 4 indicated she went two weeks without a bath a couple of months ago because things just kept happening. There were phone calls and emergencies.</p> <p>During an interview on 07/11/24 at 10:11 A.M., the resident indicated her bath days were twice a week on day shift. When she didn't get a bath, it made her feel dirty!</p> <p>The resident's clinical record was reviewed on 07/09/24 at 9:43 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/19/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, and post-polio syndrome.</p> <p>The current Care Plan for the resident's preferences, with an initiated date of 06/07/22, was provided by the Regional Administrator on 07/12/24 at 12:47 P.M., and indicated it was important to the resident to receive a bed bath two times a week.</p> <p>The SHOWER LIST was provided by the Administrator on 07/12/24 at 10:53 A.M., and indicated the resident was to get a bath/shower during day shift on Mondays and Thursdays.</p> <p>The CNA Shower Sheet paper records and the Tasks record for baths/showers from the EHR (Electronic Health Record) were provided by the DON (Director of Nursing) on 07/10/24 at 11:39 A.M., and indicated the resident received a full body bath on the following dates:</p> <ul style="list-style-type: none"> - 04/22/24, - 05/02/24, the resident went nine days without a full body bath, and - 05/09/24, the resident went six days without a full body bath, <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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 05/13/24,</p> <p>- 05/16/24,</p> <p>- 05/24/24,</p> <p>- 05/27/24,</p> <p>- 05/30/24,</p> <p>- 06/03/24,</p> <p>- 06/10/24, the resident went six days without a full body bath,</p> <p>- 06/17/24, the resident went six days without a full body bath,</p> <p>- 06/20/24,</p> <p>- 06/27/24, the resident went six days without a full body bath,</p> <p>- 07/01/24, and</p> <p>- 07/08/24, the resident went six days without a full body bath.</p> <p>The resident was to receive a bath or shower on Mondays and Thursdays. From 04/22/24 to 07/08/24, the resident should have received 23 baths. The resident had received 15 baths. No refusals were documented on the CNA Shower Sheet records or in the EHR.</p> <p>During an interview on 07/09/24 at 2:35 P.M., the Social Services Director indicated the resident was very pleasant and usually did not refuse care.</p> <p>During an interview and observation on 07/10/24 at 10:25 A.M., Corporate Nurse 6 indicated if a resident had a shower, it should be documented in the EHR. The Shower Sheets were kept for 90 days then they were shredded. The Shower Sheets were observed in a large clear plastic tub in piles.</p> <p>During an interview on 07/11/24 at 10:37 A.M., CNA (Certified Nurse Aide) 3 indicated residents were scheduled for a bath or shower twice a week, Monday through Saturday. The staff filled out a Shower Sheet with the resident's name, room number, date, and skin inspections. She signs the sheet, the resident signs it if they were coherent, and the nurse signed the sheet. They also did daily charting on the computer, and it asked about the showers. They had the opportunity to document whether the resident had a full shower, full bath, or any refusals. They had the option, on the computer system, to chart refusals. If a resident refused a shower/bath the first time, she notified the nurse and would approach the resident later. If they refused a second time, she notified the nurse. Sometimes if the nurse talked to them, they would take a shower. The Shower Sheets and the computer had the option to document refusals.</p> <p>33613</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident 15's clinical record was reviewed on 07/10/24 at 3:15 P.M. An Admission MDS assessment, dated 03/27/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but was not limited to, a stroke, hypertension, and seizure disorder. The resident was dependent on staff for all ADLs.</p> <p>The CNA Shower Sheet paper records and the Tasks record for Baths/showers from the EHR were provided by the DON on 07/10/24 3:15 P.M., and indicated the resident received a full body bath on the following dates:</p> <ul style="list-style-type: none"> - Friday, 06/07/24, full body bath, - Tuesday, 06/11/24, full body bath, - Friday, 06/21/24, full body bath and, - Tuesday, 07/09/24, full body bath. <p>The resident was to receive a bath or shower on Tuesdays and Fridays. From 06/01/24 to 07/10/24, the resident should have received 11 baths. The resident only received 4. There were only two days marked as a refusal on the bathing records.</p> <p>During an interview on 07/12/24 at 12:21 P.M., CNA 3 indicated the resident liked to stick to a routine and receive a bed bath or shower in the morning prior to breakfast. She was dependent of all ADLs. She was to receive her showers two times a week on Tuesday and Friday.</p> <p>38239</p> <p>3. On 07/11/24 at 9:24 A.M., Resident 37 indicated he didn't get his scheduled showers. Yesterday, he was in the therapy room and staff came and told him they would shower him after lunch, but they never came back to do it. Now he had to go out for an appointment without having been showered. He was supposed to get a shower twice a week. It had been a while since he'd had a shower.</p> <p>The resident's clinical record was reviewed on 07/09/24 at 12:14 P.M. An Annual MDS assessment, dated 06/26/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, CKD (Chronic Kidney Disease), obstructive uropathy, and diabetes. The resident had an indwelling urinary catheter and currently received an antibiotic for a urinary tract infection.</p> <p>The resident's Preferences Care Plan, with an initiation date of 06/25/24, indicated the resident preferred to take a shower twice a week.</p> <p>The facility Shower List was provided by the Administrator on 07/12/24 at 10:53 A.M. The list indicated the resident was to receive a shower on Wednesdays and Saturdays on day shift.</p> <p>The CNA Shower Sheet paper record and the Tasks record for baths/showers from the EHR for June and July 2024 were provided by the DON on 07/10/24 11:39 AM., and indicated the following:</p> <ul style="list-style-type: none"> - the resident declined a shower on Saturday, June 22, 2024, <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- the resident declined a shower on Wednesday, June 26, 2024, and</p> <p>- the resident received a shower on Thursday, June 27, 2024.</p> <p>A Progress Note, dated Saturday, July 6, 2024, at 9:21 P.M., indicated the resident refused to be showered per staff.</p> <p>A Progress Note, dated Wednesday, July 10, 2024, at 11:50 A.M., indicated the resident declined a shower that morning and would be offered a partial bath after lunch along with a change of clothes.</p> <p>During an interview on 07/11/24 at 1:05 P.M., QMA 2 indicated if a resident refused a shower, she would let the nurse know and come back and try again. It would be documented in the resident's record.</p> <p>The resident's clinical record indicated they were admitted to the facility on Monday, June 17, 2024, and had received one shower since admission.</p> <p>The facility admission packet was reviewed and included, under Resident Rights, regarding planning and implementing care, the resident had the right to receive the services included in the plan of care.</p> <p>The current Charting Procedure policy, dated 10/23/23, was provided by the DON on 07/12/24 at 10:10 A.M., and indicated, .PURPOSE .To accurately document in an organized manner all pertinent information related to the resident in the medical record .</p> <p>3.1-38(b)(2)</p>		

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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>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** 34232</p> <p>Based on interview, record review, and observation, the facility failed to monitor a wound for a resident who was at risk for skin breakdown for 1 of 12 residents reviewed for Quality of Care. (Resident 4)</p> <p>Findings include:</p> <p>During an interview on 07/08/24 on 10:25 A.M., Resident 4 indicated they had a wound in between their legs where the mechanical lift grabbed their leg and bites it.</p> <p>During an observation and interview on 07/10/24 at 11:08 A.M., the resident was in bed and indicated the area was on their inner thigh. It was painful. The staff gave them Tylenol and it had helped. It had looked like hamburger at one point if it didn't have a top on it. The resident clarified that the wound was from the mechanical lift.</p> <p>During an interview on 07/12/24 at 10:28 A.M., the resident indicated they had the wound probably for years, ever since the facility started using the mechanical lift. It healed then opened back up.</p> <p>The clinical record was reviewed on 07/09/24 at 9:43 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/19/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, and post-polio syndrome. The resident was at risk for pressure ulcers.</p> <p>The Nursing-New Skin Alteration assessment dated [DATE] was provided by the Regional Administrator on 07/12/24 at 11:53 A.M. The Assessment indicated, .Treatment Record (TAR) must be updated w/ (with) new skin problems. Even if no treatment is ordered it must be monitored at least daily until healed . The resident had a new wound on the right posterior upper thigh that was open and measured 5.6 cm (centimeters) x (by) 4.0 cm. The wound was red in color, non-blanchable, had uneven edges, was cool to the touch, and had no odor or drainage. Triad cream (a zinc oxide paste) was applied to the wound.</p> <p>The Nursing-Weekly Assessment records dated 05/14/24 through 07/09/24, were provided by the DON (Director of Nursing) on 07/12/24 at 11:36 A.M. The records lacked documentation the resident had any new skin alterations, including, but not limited to, wounds, rashes, excoriation, skin tears, or abrasions.</p> <p>A current Care Plan for the resident's Right posterior upper thigh skin alteration, with an initiated date of 05/13/24, was provided by the DON on 07/12/24 at 1:08 P.M. The Care Plan indicated the resident had a history of skin alterations and risk factors that included, but were not limited to, morbid obesity and immobility. The Care Plan did not indicate the skin concern had been resolved.</p> <p>The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for May 2024, was provided by the DON on 07/12/24 at 11:36 A.M. The record lacked documentation the resident's wound, identified on 05/12/24, was being monitored daily.</p> <p>(continued on next page)</p>		

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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>The Progress Notes from 05/06/24 to 07/08/24 were provided by the Regional Administrator on 07/12/24 at 12:47 P.M. The record lacked documentation regarding the resident's wound identified on 05/12/24.</p> <p>During an interview on 07/12/24 at 10:30 A.M., the DON indicated regarding skin assessments, when they found a new skin condition, they opened an initial occurrence or a new skin alteration assessment. Then the residents were followed by the Wound Nurse until the wounds were healed. They would assess the wound weekly. The weekly assessments would be under the Assessment tab on the EHR (Electronic Health Record). Even if it was a non-pressure wound it would be monitored weekly. Based on whether it was improving or declining, the Wound Nurse would consult with the providers. The DON reviewed Resident 4's New Skin Alteration assessment dated [DATE], and indicated when there was a skin alteration, the staff would monitor them in the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) daily. The new skin alteration should have been documented on the Nursing-Weekly assessment dated [DATE]. If the wound still existed, it would be documented on the Weekly assessments.</p> <p>On 07/10/24 at 11:47 A.M., incontinence care was observed for the resident with QMA (Qualified Medication Aide) 2 and CNA (Certified Nurse Aide) 3. While cleaning the resident's backside, a light pink area with irregular edges approximately the size of a half dollar was observed. The area had traces of white ointment on it with no measurable depth. As the staff cleaned the resident, a couple of small areas around the edge of the wound started to bleed slightly.</p> <p>The current nursing Charting Procedure policy, dated 10/23/23, was provided by the DON on 07/12/24 at 10:10 A.M. The policy indicated, .PURPOSE .To accurately document in an organized manner all pertinent information related to the resident in the medical record .Nursing progress notes and assessments will be completed in the EMR (Electronic Medical Record) .PERTINENT CHARTING .Documentation will be completed for all pertinent issues either in nurses progress notes or in the assessment module of the EMR . Any new physical .complaint will be documented in the EMR under the coordination assessment and/or progress note .Pertinent charting will be completed daily or more often until resolved or stable .</p> <p>3.1-37(a)</p>		