STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155049	A. BUILDING 00 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	1630 S COUNTY FARM RD WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 2, 3, 4, 7 & 8, 2025 Facility number: 000017 Provider number: 155049 AIM number: 100273830 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 14 Medicaid: 35 Other: 35 Total: 84 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 4/15/2025	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to update the care plan for 1 of 1 residents reviewed for falls (Resident 1). Finding includes: A record review was completed on 4/4/2025 at 11:40 A.M., for Resident 1. Diagnoses included, but were not limited to: chronic pain, anxiety and depression.	F 0657	It is the policy of Miller's Merry Manor, Warsaw to include all post fall interventions to the health care plan once the root cause of the fall is determined. Resident 1's health care plan has been updated to reflect the mentioned interventions on 4/7/25. All residents experiencing falls are at risk for this deficient practice.	05/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hillary Corbitt	Administrator	04/25/2025

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	A Fall assessment, dated 1/10/2025, indicated Resident 1 fell in her room while being transferred from her bed to her wheelchair by a staff member. When the staff member assisted the resident to stand, her knees buckled and the resident fell onto her right knee. A Post IDT (interdisciplinary team) Fall Risk assessment, dated 1/10/2025 indicated the root cause for Resident 1's fall was because a gait belt was not used during the transfer. The assessment indicated the staff member was counseled on the proper use of a gait belt. A Fall assessment, dated 3/13/2025 indicated Resident 1 fell attempting to toilet herself via her wheelchair. It indicated the resident was found during rounds on the bathroom floor by a staff member. The assessment indicated a new intervention to keep her bed in the lowest position was to be put into place post fall. A Care Plan, initiated on 6/16/23 indicated Resident 1 was at risk for falls due to her condition and risk factors. Interventions included and were limited to: call light within reach, explain use of assistive device upon admission, encourage and assist with wearing non-skid foot-wear, encourage resident to use handrails or assistive devices properly, evaluate effectiveness and side effects of psychotropic drugs with physician for possible decreasing of dose or elimination of medication, keep most used items in arms length to prevent bending and reaching, monitor for changes in gait and positioning, notify Physician of changes in condition and safety strips on bathroom floor. The current Care Plan related to falls did not		Effective 4/8/25, all falls are discussed in the daily clinical meeting to determine the root cause and an appropriate intervention. The involved residents care plan is updated during clinical meeting. The nurse aide assignment sheets are updated during the clinical meeting to ensure all post fall interventions are included on the care plan and implemented immediately by staff. Nurse managers and other members of the management team were educated on this process on 4/21/25. On 4/24/25 the post fall audit was completed by corporate clinical nurse, with no findings. The audit tool “Post Fall Audit” (Attachment #1) will be completed for all resident falls on an ongoing basis x3 months. All findings will be immediately acted upon and reviewed at the monthly QAPI meeting. After 3 months, the QAPI committee will determine the frequency of the audits and the number of falls to audit.	

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	include the new interventions regarding gait belt use and keeping the resident's bed in the lowest position. During an interview on 4/07/2205 at 11:01 A.M., the DON indicated the residents care plan should have been updated with the new fall interventions. On 4/7/2025 at 12:00 P.M., the DON provided a policy titled, "Care Plan Development and Review," dated 1/24/2020 and indicated it was the policy currently being used by the facility. The policy indicated ...."3. Care Plan Revision: A. Care plans will be revised daily and PRN as changes in the residents condition dictate. Changes include but are not limited to changes in Physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes etc...." 3.1-35(d)(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, record review and interview, the facility failed to provide independent leisure activities for 1 of 2 residents reviewed for activities. (Resident 61) Finding includes: During an observation, on 4/2/2025 at 9:34 A.M. and 2:40 P.M., Resident 61 was observed in bed with her eyes closed without any visual or hearing sensory activities. During an observation, on 4/3/2025 at 2:17 P.M., Resident 61 was observed in bed with her eyes closed without any visual or hearing sensory	F 0679	It is the policy of Miller's Merry Manor, Warsaw to provide group and/or individual activities based upon each resident's preference. Resident 61 is at the end of her life and on palliative care. The care goal for resident 61 is to maintain comfort. Music will be provided at bedside for stimulation while she rests in bed. All residents are at risk for this deficient practice. Life Enrichment Director and/or designee will review activity care plans of residents that have	05/01/2025

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	activities. During an observation, on 4/4/2025 at 10:51 A.M., Resident 61 was observed in her Broda chair at the bedside with her eyes closed. There were no stimulating activities occurring in her room. During an observation, on 4/7/2025 at 8:56 A.M., Resident 61 was observed sitting in the hallway outside her room in a Broda chair. At 9:41 A.M. and 1:53 P.M., she was observed in her bed with her eyes closed and without any visual or hearing sensory activities. During an observation, on 4/8/2025 at 10:21 A.M., Resident 61 was observed in her bed with her eyes closed. A record review for Resident 61 was completed on 4/3/2025 at 1:46 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, seizures, aphasia, mood disorder and altered mental status. Resident 61 received end of life care. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/2025, indicated Resident 61 was rarely or never understood and was dependent on staff for wheelchair locomotion. An Annual MDS assessment, dated 09/25/2024, indicated Resident 61's activity preferences were somewhat important for listening to music, having animals around, participating in activities with groups of people, participating in her favorite activities, getting fresh air when the weather was good and participating in religious services or practices. A Care Plan, initiated on 8/18/2023, indicated the Resident was considered cognitively impaired,		minimal activity participation in a group setting, to ensure activity preferences are being offered and/or provided. The Audit tool entitled “Activity Preferences” (Attachment #2) will be completed weekly x4, then monthly x5 months. All findings will be acted upon and reviewed in the monthly QAPI meeting. After 6 months, the QAPI committee will determine frequency of audits based upon findings.	

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	was not capable of making decisions about activity involvement and would benefit from sensory related activities. The interventions included, but were not limited to: at times, Resident 61 preferred to vary her rest periods between morning and afternoon, through past history and/or family/resident interview it had been determined that religion had always been important and staff would provide religious music, opportunities to watch services on the television or special local church tapes, and Resident 61 always enjoyed music. During an interview, on 4/8/2025 at 8:54 A.M., the Activity Director indicated Resident 61 was not typically taken to the activity programs, but would generally receive a sensory activity once a week since she was the only activity staff working recently. She indicated Resident 61 was generally in bed. She indicated music was available in the resident lounge on the television and she tried to take Resident 61 to church services every other week. During an interview, on 4/8/2025 at 10:30 A.M., LPN 2 indicated Resident 61 laid down in bed after breakfast and lunch. She indicated Resident 61 sometimes attend a sensory activity a couple times a week. A policy was provided, on 4/8/2025 at 10:14 A.M., by the director of Nursing (DON). The policy titled, "Enrichment Program Guidelines", indicated, " ...1. Purpose A. To enhance the lives of our residents through activity involvement. Benefits include: decreased behaviors, and increase overall satisfaction, and quality of life ...III. Level 1/2 [these are lowest functioning-typically the ones who sleep during activities-they need sensory stem] a. Sensory			

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	stem-daily before lunch and supper- this will wake them up and stimulate appetite b. Musical programs c. spiritual activities d. Gross Motor movement active exercises-slow repetitive movements ie repetitively clapping hands to music, etc. at least 2 times a week ...." 3.1-33(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to provide the recommended laboratory work recommended per the facility dietician for 1 of 3 residents reviewed for nutrition. (Resident 76) Finding includes: A record review for Resident 76 was completed on 4/3/2025 at 1:09 P.M. Diagnoses included, but were not limited to: fracture of the left femur, mild cognitive impairment and chronic kidney disease stage 3b. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident 76 was cognitively intact and had a stage 2 and 3 pressure ulcer that were not present on admission. A Nursing Progress Note, on 12/2/2024 at 5:47 P.M., indicated Resident 76 had laboratory kidney function values of a blood urea nitrogen of 96 mg/dL (milligrams per deciliters) with a normal range of 7-20 mg/dL and a creatinine of 2.9 mg/dL with a normal range of 0.7-1.3 mg/dL.. An Admission/Annual/Significant Change/Other Registered Dietician Assessment, dated 1/2/2025, indicated to nursing a suggestion to monitor	F 0692	It is the policy of Miller's Merry Manor, Warsaw to communicate dietician recommendations to the NP or MD that is following the resident's care in the facility. Resident 76's Nurse Practitioner was notified during state survey of the 1/2/25 dietary recommendation and the lab results in December, which was reviewed again. New order was given on 4/7/25 to draw labs on 5/1/25. All residents are at risk for this deficient practice. Director of Nursing and Dietary Manager will make copies of all RD recommendations and will complete them within 7 days. If a recommendation is questionable, a nurse manager will discuss with RD. Physician and/or NP will be notified of health concerns expressed by RD and this notification will be documented in the medical record. To ensure continued compliance, the audit tool entitled "Dietician	05/01/2025

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	kidney function due to high protein supplementation and chronic kidney disease stage 3. The assessment indicated Resident 76 received greater than 107 grams of protein per day with supplementation and dietary recommendations. This was an increase from the recommended supplementation from 12/30/2024 of greater than 80 grams of protein per day. A Registered Dietician Note, on 1/2/2025 at 3:43 P.M., indicated the registered dietician assessment was completed and suggested lab monitoring for kidney function due to high protein supplementation with a diagnosis of chronic kidney disease stage 3. A Care Plan, initiated 11/25/2024, indicated Resident 76 was at nutritional risk related to chronic kidney disease stage 3, mild cognitive impairment, hypertension, anemia and pressure injury. Interventions included, but were not limited to: serve 8 ounces of milk and 4 ounces of orange juice at all meals, serve 4 ounces of super cereal at breakfast, serve 1-ounce additional protein at breakfast, oral pharmaceutical supplements as ordered: Ensure 237 milliliters twice daily and protein supplementation: ProHeal 30 milliliters twice daily. During an interview, on 4/7/2025 at 10:40 A.M., the Director of Nursing (DON) indicated recommendations from the registered dietician should be followed and the registered dietician usually puts a note in the medical record for recommendations. During an interview, on 4/7/2025 at 11:10 A.M., the DON indicated the registered dietician was not aware of laboratory results available in the medical record from 12/2/2024.		Recommendation Audit" (Attachment #3) will be completed following each RD onsite or remote visit. Any concerns identified with follow through of recommendations will be immediately corrected. Auditing will be completed for 6 months. All findings will be reviewed at the monthly QAPI meeting. After 6 months, the QAPI committee will determine the frequency of audits based upon findings.	

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	During an interview, on 4/8/2025 at 8:47 A.M, the DON indicated the registered dietician did not know laboratory results were available in the medical record from 12/2/2025 and the nurse practitioner would not have drawn labs until six months after the laboratory results from 12/2/20205. However, there was no indication the MD or NP were made aware of the increased protein and the dietician's recommendation to closely monitor the resident's kidney function. A policy was provided, on 4/8/2025 at 10:14 A.M., by the DON. The policy titled, "Dietician Clinical Communication", indicated, " ...The Dietary Manager will communicate clinical information to and from the consultant dietician and interdepartmentally ...C. The Consultant Dietician or designee will: Make recommendations as needed. Communicate the recommendations and other comments/concerns to the Dietary Manager. D. The Dietary Manager will: Communicate recommendations, other comments and concerns to other departments for their follow-up. 3.1-46(a)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately and were labeled and dated for 1 of 3 medication carts observed. (Windsor 1) Finding includes:	F 0761	It is the policy of Miller's Merry Manor, Warsaw to properly label and store all medications and biologicals according to professional principles. All undated and opened items were destroyed and re-ordered during survey. Remaining	05/01/2025

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	During a medication storage observation, on 4/7/2025 at 2:00 P.M., with QMA 4, the following was observed: - an opened and undated bottle of dorzolamide eye drops with no resident identifiers. - an unsealed and unlabeled package of petrolatum gauze dressing. - an open and undated bottle of lactulose (stool softener). During an interview, on 4/07/2025 at 2:09 P.M., QMA 4 indicated the eye drops should have been labeled and dated. The lactulose should have been dated and the gauze dressing should have been sealed and labeled. On 4/8/2025 at 8:39 A.M., the Director of Nursing provided the policy titled, "Storage of Medications", dated, 12/26/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...3. All medications dispensed by the pharmacy are stored in the container with the pharmacy label... 8. ...Expiration Dating... 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. A. The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration...." 3.1-25(j)		medication carts were examined and no issues observed. All residents are at risk for the deficient practice. All nurses and QMA's will be re-educated on medication storage, dating items when opening, and ensuring all eye drops are identified with resident names on 5/1/25. The audit tool entitled "Medication Cart & Infection Control Audit" (Attachment #4) will be completed 2x weekly on all medication carts for 1 week, then weekly x3 weeks, then every other week x2 , then monthly x4 months. All findings will be immediately acted upon and reviewed in the monthly QAPI meeting. After 6 months, the QAPI committee will determine the frequency of audits based upon the audit findings.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to follow general Infection Control Practices for 1 of 1 staff observed providing a skin treatment and failed to	F 0880	It is the policy of Miller's Merry Manor, Warsaw to follow infection control practices, to help prevent the development and transmission	05/01/2025

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	use a barrier when obtaining a blood sugar sample for 1 of 1 staff observed for insulin administration. (LPN 2 & RN 5) Findings include: 1. During an observation, on 4/4/2025 at 10:00 A.M., LPN 2 was observed to complete a skin treatment on Resident 145's inner left glueteal cleft. LPN 4 applied gloves and assisted Resident 145 to lay on his right side. LPN 4 removed the dressing from the resident's inner cleft, then removed her right-hand glove and applied a new glove. LPN 4 opened a package of comfort foam dressing. She applied a small amount of Medi-honey (wound gel) to a cotton tipped applicator and then applied the gel to the left gluteal cleft. LPN 4 then placed the foam dressing over the open area. LPN 4 removed the right-hand glove, then used a marker to write the date on the dressing. She applied a new glove to her right hand and assisted the resident to position in the bed. She then applied skin prep (skin barrier) to an area on Resident 145's right heel. LPN 4 then applied skin prep to an area on the resident's left ankle. She then removed both gloves and assisted the aide in placing the bed spread on the bed. During an interview, on 4/4/2025 at 10:14 A.M., LPN 4 indicated she should have washed her hands after removing the old dressing and after removing her gloves. 2. During a medication observation, on 4/8/2025 at 11:00 A.M., RN 5 was observed to obtain a blood sample. RN 5 disinfected her hands and then applied a gown, mask, and gloves. She entered the residents' room and placed the glucometer (device to monitor blood glucose levels) on the bedside table. She used an alcohol pad and wiped the		of communicable diseases and infections. LPN #2 was re-educated on handwashing with glove use and soiled dressing removal. RN #5 was re-educated on practice of providing a clean surface when using equipment at the resident's bedside. All residents with a treatment or glucometer testing are at risk for this deficient practice. All nurses and QMA's will be re-educated on principles of infection prevention and control as they relate to bedside treatments, glucometer testing, glove use and handwashing on 5/1/25. The audit tool entitled "Medication Cart & Infection Control Audit" (Attachment #5) will be completed on random nurses and QMA's 2x weekly for 1 week, then weekly x3 weeks, then every other week x2, then monthly x4 months. Re-educating will be provided on the spot for any break in infection control practices. All findings will be reviewed in the monthly QAPI meeting. After 6 months, the QAPI committee will determine the frequency of audits based upon audit findings.	

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	residents' finger and obtained the blood sample. RN 5 placed the glucometer device back on the table. RN 5 did not place any type of barrier on the table before placing the glucometer on the table. During an interview, on 4/8/2025 at 11:10 A.M., RN 5 indicated she probably should have placed a barrier on the table. 3.1-18(a)			