STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING 00 B. WING	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 4, 5, 6 & 7, 2025 Facility number: 000041 Provider number: 155102 AIM number: 100275400 Census Bed Type: SNF: 3 SNF/NF: 65 Total: 68 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 20 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 2/14/2025	F 0000		
F 0567 SS=E Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds Based on interviews and observation, the facility failed to ensure resident funds were immediately available during non-business hours. This deificent practice had the potential to affect 24 of 24 residents with trust funds. Finding includes: During an interview, on 2/5/2025 at 9:25 A.M.,	F 0567	F-567 Protection/ Management of Personal Funds It is the policy of Miller's Merry Manor to ensure that resident funds are made immediately available during non-business hours. Resident Funds will be made available at the business office	03/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryan Zehr	Administrator	02/27/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Resident 12 indicated the facility had informed him he could only get his resident trust account funds when the business office was open. During an observation, on 2/7/2025 at 10:43 A.M., a sign at the front receptionist's desk was observed with the following: "Resident Trust Funds Availability For those residents who have a Resident Trust Fund account with [facility name]: These funds are available to you seven [7] days a week, during the following times: Business Office Monday-Friday 8:30am-4:30pm ICF 1's Nurse's Station Saturday & Sunday 10:00am-2:00pm ...." During an interview, on 2/7/2025 at 10:45 A.M., the Business Office Manger indicated residents could obtain their money during business hours, Monday through Friday and there was a time perimeter on Saturday and Sunday for residents to obtain resident trust money. She indicated the facility placed a time frame for the access and availability of funds. During an interview, on 2/7/2025 at 1:42 P.M., the Executive Director indicated monies, from Resident Trust funds, were available at the nurse's station after business office hours. He indicated the facility preferred to complete financial transactions during business hours. During an interview, on 2/7/2025 at 1:44 P.M., CNA 10 indicated resident funds were not available outside of the facility's business hours. During an interview, on 2/7/2025 at 1:52 P.M., RN 5, who worked on the ICF (intermediate care facility) hallway, indicated she did not have Resident Trust money available after business hours in her medication cart for the residents to		Monday through Friday 8:30 am to 4:30 pm. A petty cash box will be made accessible at the Rehab Nurses Station to all residents who have resident's trust funds during non-business hours. This will be completed by Office Manager or Designee daily Monday through Thursday and left Friday through Sunday for weekend and holiday transactions. All facility signs have been updated and placed at the front lobby and at nurses' stations (Attachment I) All residents who have resident's trust funds have the potential to be affected by this deficient practice. To ensure that this deficient practice does not recur all staff will be in-serviced on resident funds and the location of resident funds petty cash box for non-business hours transactions (Attachment J). Resident Council will be updated on changes in hours for Resident Funds. To monitor the corrective actions and ensure the deficient practice will not recur, the Office Manager /Designee will complete the QA Tool titled, Annual Survey 2-7-25, (Attachment A 1). This tool will be completed daily (M-F) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the	

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	access. A current policy was provided by the Director of Nursing, on 2/7/2025 at 1:25 P.M. The policy titled, "Resident Fund Procedures", indicated, " ...3. Funds should be readily available for residents. It is suggested that the family members and/or the resident be advised of the business office hours at the time of admission. Money is not available when the business office is not open; therefore, money is not available on weekends or evenings ...."		audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the physician was notified of abnormal blood sugar results for 1 of 1 residents reviewed for physician notification. (Resident 54) Findings include: 1. The record for Resident 54 was reviewed on 2/6/2025 at 3:57 P.M. Diagnoses included, but were not limited to: hemiplegai, neurogenic bladder, diabetes and cancer. A Quarterly Minimum Data Set (MDS) assessment, dated 1/22/2025, indicated the resident received antidepressant and hypoglycemic medications. Current Physician Orders for Resident 54 included the following: - Humalog Inject 15 units subcutaneously three times a day for diabetes. Give 15 minutes AC (before) meal/snack. Notify MD if BS (blood sugar) less than 100 or greater than 400. If s/s (signs/symptoms) present, follow blood sugar	F 0580	**F- 580 Notify of Changes** It is the policy of Miller's Merry Manor to keep the physician appraised of all condition changes which includes values outside of ordered parameter monitoring. Immediate action to correct the deficient practice was notification to the physician informing of the blood sugar values outside of the call parameter. All residents have the potential to be affected by the same deficient practice. An audit has been completed on all resident with blood sugar call parameters. No other residents were affected by this deficient practice. To ensure that the deficient practice does not recur all nurses will be in-serviced on the policy titled, Physician & Family Notification of Condition Change	03/03/2025

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	flowchart and document in progress note. Hold if blood sugar is less than 150. - Glargine insulin -Inject 32 units subcutaneously one time a day for diabetes. Hold if BS is less than 100 or greater than 400 and notify the MD. Monitor for s/s of hypo/hyperglycemia and notify MD if present. A current Care Plan, initiated on 6/17/2024, included the following interventions: Give medications as ordered. Monitor blood sugar as ordered. Notify MD of blood sugar readings outside the ordered parameters. The November Medication Administration Record (MAR) indicated the following blood glucose result: - 11/3 the blood sugar result was 71 mg/DL. - 11/4 the blood sugar result was 83 mg/DL. - 11/7 the blood sugar result was 96 x 2 mg/DL. - 11/8 the blood sugar result was 98 x 2 mg/DL. - 11/9 the blood sugar result was 87 mg/DL. - 11/11 the blood sugar result was 91 mg/DL. - 11/17 the blood sugar results were 84 & 96 mg/DL. - 11/21 the blood sugar result was 96 mg/DL. - 11/22 the blood sugar results were 77 x 2 mg/DL. - 11/24 the blood sugar result was 98 mg/DL. - 11/25 the blood sugar result was 82 mg/DL. - 11/29 the blood sugar result was 80 mg/DL. The Nursing Progress Notes for November lacked documentation indicating the physician had been notified of the abnormal blood sugar results. The December MAR indicated the following blood glucose results: - 12/1 the blood sugar result was 84 x 2 mg/DL. - 12/3 the blood sugar result was 88 mg/DL. - 12/6 the blood sugar result was 85 mg/DL.		(Attachment B). To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 2-7-2025 Nursing, (Attachment A2). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025	

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	- 12/7 the blood sugar result was 98 mg/DL. - 12/9 the blood sugar results were 97 x 2 mg/DL. - 12/11 the blood sugar result was 96 mg/DL. - 12/13 the blood sugar result was 94 mg/DL. - 12/16 the blood sugar result was 87 mg/DL. - 12/23 the blood sugar result was 93. mg/DL - 12/25 the blood sugar result was 85. mg/DL - 12/27 the blood sugar result was 94 mg/DL. - 12/29 the blood sugar result was 88 mg/DL. - 12/30 the blood sugar result was 80 mg/DL. - 12/31 the blood sugar result was 96 mg/DL. The Nursing Progress Notes for December lacked documentation indicating the physician had been notified of the abnormal blood sugar results. The January 2025 MAR indicated the following blood glucose results: - 1/1 the blood sugar result was 88 mg/DL. - 1/3 the blood sugar results were 98 and 92 x 2 mg/DL. - 1/4 the blood sugar result 74 and 70 mg/DL. - 1/7 the blood sugar result was 75 mg/DL. - 1/8 the blood sugar result was 82 mg/DL. - 1/9 the blood sugar results were 68 and 72 mg/DL. - 1/10 the blood sugar results were 99 and 83 mg/DL. - 1/12 the blood sugar result was 69 mg/DL. - 1/13 the blood sugar result was 92 mg/DL. - 1/15 the blood sugar result was 82 mg/DL. - 1/16 the blood sugar results were 90 x 2 mg/DL. - 1/17 the blood sugar result was 99 mg/DL. - 1/19 the blood sugar result was 80 mg/DL. - 1/24 the blood sugar result was 72 mg/DL. - 1/29 the blood sugar result was 95 mg/DL. - 1/31 the blood sugar result was 88 mg/DL. The Nursing Progress Notes for December lacked documentation indicating the physician had been			

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	notified of the abnormal blood sugar results. During an interview, on 2/7/2025 at 1:08 P.M., the Director of Nursing indicated the physician should have been notified. On 2/7/2025 at 1:08 P.M., the Director of Nursing provided the policy titled, "Physician & Family Notification of Condition Changes", dated 5/14/2024, and indicated the policy was the one currently used by the facility. The policy indicated "... II. Notify the physician of any change in the condition that may or may not warrant a change in the treatment plan. III. Notify the physician when values monitored are outside of ordered parameters...." 3.1-5(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observations, record review and interview, the facility failed to provide activities for a dependent resident for 1 of 3 residents reviewed for activities. (Resident 40) Finding includes: During an observation, on 2/4/2025 at 9:46 A.M.,10:56 A.M. and 2:49 P.M., Resident 40 was observed in her room without visual or auditory stimulation. During an observation, on 2/5/2025 at 10:49 A.M., Resident 40 was seated in a reclined position in her Broda chair in her room without visual or auditory stimulation. During an observation, on 2/5/2025 at 3:04 P.M.,	F 0679	F-679 Activities meet interest/ needs of each resident It is the policy of Miller's Merry Manor to provide ongoing programing to support residents in their choice of activities, both facility- sponsored group and individual activities and independent activities to meet their interests of and support the physical, mental, and psychosocial well-being of each resident. All dependent residents Activities Care plans have been updated. Activities Director/ designee will round to ensure that all of the	03/03/2025

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	Resident 40 was observed in her bed sleeping. During an observation, on 2/6/2025 at 11:02 A.M., Resident 40 was observed in her room without visual or auditory stimulation. A record review for Resident 40 was completed on 2/6/2025 at 1:12 P.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia, dementia and delirium. A Quarterly Minimum Data Set (MDS) assessment, dated 1/31/2025, indicated Resident 40 was severely cognitively impaired and received hospice care. A current Care Plan, initiated 11/25/2022, indicated Resident 40 enjoyed increased socialization/stimulation received through involvement in group activities. Interventions included, but were not limited to: -Would attend sensory activities. -Make sure Resident 40 received invitations to readings. -Encourage family to bring in radio/tape player for Resident 40 to keep in her room. -Activities would invite to all current events, educational activities and group activities. -Resident 40 enjoyed activities including: small groups, current events, outside, games and possibly arts/crafts. -Resident 40 stated she currently enjoyed watching television shows such as Hallmark types of shows. -Need assist to/from activities. A current Care Plan, dated 5/3/2024, indicated Resident 40 was at risk for feelings of loneliness or feeling self-isolated. Interventions included, but were not limited to: assist Resident 40 in		interventions are in place for each of these residents. These interventions include but not limited to: one on one sensory activities, reading activities, current events, games, music, and television programs. All dependent residents have the potential to be affected by this deficient practice. No other residents were affected by this deficient practice. To ensure that this deficient practice does not recur all staff will be in-serviced on activities for dependent residents. Activities Individual Programming (Attachment K). Activities staff will round to ensure that interventions are in place when residents are in room. Residents will be invited to attend group activities per their interests. To monitor the corrective actions and ensure the deficient practice will not recur, the Activities Director /Designee will complete the QA Tool titled, Annual Survey 2-7-2025, (Attachment A3). This tool will be completed daily (M-F) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to	

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	finding services, equipment or activities they enjoy (i.e. books on tape, music lessons, games and stationery) and invite and encourage out-of-room activities. Despite the care planned interventions to address activity preferences and combat lonliness and isolation, Resident 40 was not observed in an activity, nor with visual or auditory stimulation in her room. During an interview, on 2/7/2025 at 9:52 A.M., the Activity Director indicated Resident 40 was involved in sensory activities, passive watching and 1:1 visits. She indicated Resident 40 should have had a visual or auditory activity in her room. A current policy was provided, on 2/7/2025 at 1:25 P.M., by the Director of Nursing. The policy titled, "Life Enrichment Program Guidelines", indicated, " ...To enhance the lives of our residents through activity involvement. Benefits include: decreased behaviors, and increased overall satisfaction, and quality of life ...." 3.1-33(b)(8)		determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow physician orders for daily weights and failed to transcribe physician orders accurately for 2 of 22 residents whose physician orders were reviewed. (Residents 55 & 267) Findings include: 1. The record for Resident 55 was reviewed on 2/6/2025 at 1:58 P.M. Diagnoses included, but	F 0684	**F- 684 Quality of Care** It is the policy of Miller's Merry Manor to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration and that orders are followed as written.	03/03/2025

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	were not limited to: diabetes, dementia, depression and anxiety. A Physician's Order, dated 2/19/2025, indicated an order for daily weight-after voiding and before breakfast/medications with the same clothes every day shift. A current Care Plan for nutrition, dated 1/10/2025, indicated the resident was at nutritional risk related to: Potential for weight fluctuations related to fluid shifts and receives diuretic therapy. Interventions included but were not limited to: Diet is served as ordered. Select my own menus. Monitor weights and intakes. The November weight documentation and Nursing Progress Notes, from 11/1/2024 through 11/30/2024, lacked daily weights and/or documentation of why the daily weight was not obtained for the following dates: 11/9, 11/10, 11/18, 11/23 and 11/28/2024. The December weight documentation and Nursing Progress Notes, from 12/1 through 12/31/2024, lacked daily weights and/or documentation of why the daily weight was not obtained for the following dates: 12/7, 12/12, 12/16, 12/21, 12/22, 12/30 and 12/31/2024. The January weight documentation and Nursing Progress Notes, from 1/1 through 1/31/2025, lacked daily weights and/or documentation of why the daily weight was not obtained for the following dates: 1/1, 1/2, 1/4, 1/5, 1/6, 1/9, 1/13, 1/19 and 1/27/2025. During an interview, on 2/7/2025 at 9:15 A.M., the Director of Nursing indicated the resident should		Immediate action to correct was taken. Physician was notified and orders reviewed with no changes made to transcribed orders. Physician discontinued the daily weight on resident as it was deemed no longer necessary due to resident is stable and long-term care. All residents have the potential to be affected by the same deficient practice. All residents with daily weight orders were reviewed along with residents admitted in the last 30 days new admission orders were audited for accuracy in transcription. No other residents were affected by this deficient practice. To ensure that the deficient practice does not recur all nurses will be in-serviced on the policies titled, New Order Transcription (Attachment C). Special emphasis/focus will be given on attention to dose of medication along with following orders once transcribed. Heart Failure Care Guideline Policy (Attachment D) will also be reviewed to discuss daily weight orders. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 2-7-2025 Nursing,	

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	have been weighed daily and on the missed days, the facility should have documented in the Nursing Progress Notes as to why the weights had not been obtained. On 2/7/2025 at 1:08 P.M., the Director of Nursing indicated the facility did not have a policy regarding weights.2. A record review for Resident 267 was completed on 2/6/2025 at 9:38 A.M. Diagnoses included, but were not limited to: depression, end stage renal disease, dysphagia and diabetes mellitus type two. A Care Plan, initiated on 2/5/2025, indicated Resident 267 had depression and required the use of an antidepressant. A discharge medication order list from [Name of Hospital], dated 1/31/2025, included: sertraline (an antidepressant) 50 milligram (mg) tablet take 0.5 tablet (25 mg) by mouth at bedtime. However, the sertraline order was incurrately transcribed as 50mg 1 tablet by mouth at bedtime on the facility's admission orders. A Medication Administration Record (MAR), dated February 2025, indicated Resident 267 received sertraline 50mg on six of six days, instead of the 25mg by mouth at bedtime as per the medication order list. A Nursing Progress Note, dated 1/31/2025, indicated the Nurse Practioner had clarified a heparin order from the Resident's discharge medication orders, but there was no evidence in Resident 267's medical record the order for the sertraline was reviewed and increased from 25mg to 50mg. During an interview, on 2/7/2025 at 9:11 A.M., RN		(Attachment A2). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025	

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	9 indicated the facility used the discharge medication list from the hospital. She indicated Resident 267 should have been on sertraline 25mg daily. During an interview, on 2/7/2025 at 10:40 A.M., the ADON indicated she had had a conversation with the NP regarding Resident 267 sertraline. She stated the NP did not feel that sertraline 25 mg would be effective, so she ordered sertraline 50mg. The ADON indicated she did not document this conversation in the medical record. A current facility policy provided by the DON on 2/7/2025 at 11:30 A.M., titled "New Order Transcription", indicated: "to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration". 3.1-37 (a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure a PRN (as needed) antianxiety medication was not ordered/used for more than 14 days and lacked documentation for the use of an antipsychotic for 2 of 6 residents reviewed for unnecessary medications. (Resident 19 & 39) Findings include: A record review for Resident 19 was completed on 2/6/2025 at 11:36 A.M. Diagnoses included but were not limited to Alzheimer's, psychotic disorder with delusions, and anxiety. A Quarterly Minimum Data Set (MDS)	F 0758	**F- 758 Free of Unnecessary Psychotropic Meds/PRN Use** It is the policy of Miller's Merry Manor that psychotropic medications will only be used when medically indicated to treat a specific condition and for the duration clinically indicated to treat the resident's assessed condition(s). The deficient practice was immediately correct by clarifying the DX for the antipsychotic med	03/03/2025

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	155102	A. BUILDING 00 B. WING	02/07/2025

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	assessment, dated 11/26/2024, indicated Resident 19 had exhibited signs of delusions but had not exhibited any other behaviors. The assessment also indicated Resident 19 had not received any psychotropic medications. A Physician's Order, dated 1/8/2025, and discontinued on 2/4/2025, indicated lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 4 hours as needed (PRN) for anxiety. A Physician's Order, dated 2/4/2025, and with a stop dated of 5/1/2025, indicated lorazepam 0.5mg by mouth every 4 hours PRN for anxiety. A Care Plan, initiated on 1/16/2025, indicated Resident 19 had a PRN anxiolytic (an anti-anxiety medication). A consultant pharmacist communication to the physician, dated 1/30/2025, and signed by the Nurse Practitioner (NP) on 2/5/2025, indicated "the mega rule only allows 14 days of PRN anxiolytics: however, physician can document in the medical record why it is needed longer ...". The NP indicated on the form terminal agitation, with no supportive documentation of the terminal agitation in the medical record for Resident 19. Nursing progress notes, from 12/23/2024 to 2/6/2025, did not indicate Resident 19 had exhibited any behaviors, anxiety or agitation to support the "terminal agitation" documented by the NP. A Physician's assessment, dated 1/9/2025, did not indicate why the PRN lorazepam was initiated and ordered longer than 14 days. During an interview, with the Director of Nursing (		with the physician and adding a time frame to the prn antianxiety order and has since been discontinued due to nonuse. All residents have the potential to be affected by the same deficient practice. All other orders for antipsychotic medications reason for giving was audited to make sure it is appropriate. All other orders for PRN psych medications were audited for time frames. No other residents were affected by this deficient practice. To ensure that the deficient practice does not recur all nurses will be in-serviced on the policy titled, Psychotropic Medication Use (Attachment E), with special emphasis put on antipsychotic medications appropriate reasons for usage and time frames requires on PRN psych medication orders. To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 2-7-2025 Nursing, (Attachment A2). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the	

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	DON) on 2/7/2025 at 9:43 A.M., she indicated she was unsure why the lorazepam was initiated or why it had been ordered for more than 14 days.2. On 2/6/2025 at 9:53 A.M., a record review was completed for Resident 39. Diagnoses included, but were not limited to: anxiety and dementia. A Quarterly MDS (Minimum Data Set), dated 1/3/2025 indicated Resident 39's cognition was significantly impaired and the resident used an antipsychotic medication on a daily basis. Current Physician's Orders, dated 11/28/2024 indicated Resident 39 received Seroquel (antipsychotic) oral tablet 50 mg (milligrams) by mouth at bedtime and quetiapine fumurate 100 mg tablet by mouth one time a day for a diagnosis of anxiety and combative behaviors. Resident 39's record lacked documentation of a medical indication to support the use of Seroquel. During an interview on 2/06/2025 at 1:46 P.M., the DON indicated Resident 39 did not have an appropriate diagnosis for the use of Seroquel. On 2/6/2025 at 2:49 P.M., the DON provided a policy titled, "Psychotropic Medication Use," dated 2/18/2019 and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To ensure that medication regimen helps promote or maintain the residents highest practicable mental, physical, and psychosocial well-being as identified by the resident and/or representative(s) in collaboration with the attending physician/psychiatrist and facility staff; each resident receives only those medications, in doses and for the duration clinically indicated to treat the residents assessed condition(s); 1. The facility will assure that		audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025	

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	medication therapy is based upon an adequate indication for use by documenting the supporting diagnosis/indication of use at the time the order for psychotropic medication is obtained/received....." A current facility policy provided by the DON, on 2/7/2025 at 11:30 A.M., titled "Psychotropic Medication Use" indicated, " ...PRN orders will be limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN to be extended beyond the 14 days. He/she should document their rationale in the resident's medical record ...." 3.1-48(a)(4)			
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 over the counter medications were labeled properly and failed to ensure opened medications were dated when opened for 1 of 4 medication storage areas observed. (ICF 3 medication cart) Finding includes: On 2/6/2025 at 2:22 P.M., a medication storage observation of the ICF 3 medication cart was completed with RN 5 and the following was observed: - a bottle of ibuprofen 200 mg (milligrams) with no resident label. - an opened and unlabeled bottle of CoQ10. - an opened and unlabeled bottle of Vitamin D 3. - an opened and unlabeled bottle of aspirin 81 mg. - an opened and unlabeled bottle of Ferrosol 325 mg.	F 0761	**F- 761 Label/Store Drugs & Biologicals** It is the policy of Miller's Merry Manor that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Immediately upon being identified all medications were labeled and dated appropriately. All residents have the potential to be affected by the same deficient practice. An audit was completed and no other medications were found to lack labeling or dates.	03/03/2025

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	- an opened and unlabeled bottle of Milk of Magnesia (MOM). - a bottle of Men's multi vitamin with no resident label. - a box of daily probiotic pills with no label. - an opened and undated bottle of Guaifenesin liquid. - 2 opened and undated bottles of MOM. During an interview, on 2/6/2025 at 2:36 P.M., RN 5 indicated the medications should have been labeled and should have had opened dates on them. On 2/7/2025 at 1:08 P.M., the Director of Nursing provided the policy titled, "Medication Labels", dated 4/24/2019, and indicated the policy is the one currently used by the facility. The policy indicated "... Medications are labeled in accordance with facility requirements and state and federal laws...." 3.1-25(k)		To ensure that the deficient practice does not recur all nurses will be in-serviced on the policy titled, Storage of Medications (Attachment F) and the Medication Storage Guide (Attachment G). To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 2-7-2025 Nursing, (Attachment A2). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and	F 0880	**F- 880 Infection Prevention &**	03/03/2025

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	interview, the facility failed to provide enhanced barrier precautions (EBP) for a resident with a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 46) Finding includes: During an interview, on 2/4/2025 at 10:28 A.M., Resident 46 indicated he had had a sore on his buttock for the past three weeks. A record review for Resident 46 was completed on 2/6/2024 at 9:45 A.M. Diagnoses included, but were not limited to: heart failure, diabetes mellitus type 2, obesity, polyneuropathy and edema. A Quarterly Minimum Data Set (M.DS) assessment, dated 1/31/2025, indicated Resident 46 was cognitively intact and had a Stage 2 pressure ulcer. A Pressure Injury Note, dated 1/2/2025 at 12:03 P.M., indicated a new in-house stage 2 pressure ulcer was observed to the left mid-buttock. A Physician's Order, dated 1/28/2025, indicated to cover the wound with Duoderm (moisture-resistant wound dressing) every Tuesday and as needed if displaced or soiled. A Care Plan, dated 1/2/2025, indicated Resident 46 had a pressure ulcer. The goal was the wound would not show any signs or symptoms of infection. During an observation, on 2/7/2025 at 10:23 A.M., RN 5 held Resident 46's lower garments and removed his incontinence brief to expose the pressure ulcer. RN 5 had gloves placed on her hands, but was not wearing a gown when this		**Control** It is the policy of Miller's Merry Manor to prevent the spread of multi drug resistant organisms (MDRO) from one resident to another resident via health care workers hands and clothing and to protect vulnerable residents. Resident with wound identified was immediately placed in Enhance Precautions. All residents with wounds have the potential to be affected by the same deficient practice. All residents with wounds was audited and were in enhanced precautions. No other residents were affected by this deficient practice. To ensure that the deficient practice does not recur all nurses will be in-serviced on the policy titled, Enhanced Precautions for novel and targeted MDRO's (Attachment H). To monitor the corrective actions and ensure the deficient practice will not recur, the DON/Designee will complete the QA Tool titled, Annual Survey 2-7-2025 Nursing, (Attachment A2). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and	

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	assistance was provided. During an interview, on 2/7/2025 at 10:27 A.M., CNA 4 indicated she was aware of residents in enhanced barrier precautions by the signage on the resident's door. She indicated if a resident had a pressure wound beyond stage 1, enhanced barrier precautions should be in place. During an interview, on 2/7/2025 at 10:36 A.M., RN 5 indicated enhanced barrier precautions should be in place for residents with an indwelling catheter, colostomy bags, wounds and residents with multi drug-resistant organisms. She indicated she would know a resident had enhanced barrier precautions by the sign on the door and by the orders in electronic medical record. However, during an observation, on 2/7/2025 at 10:42 A.M., there was no sign on Resident 46's door to indicate enhanced barrier precautions were needed or a physician's order to indicate enhanced barrier precautions were needed. A current policy was provided by the Director of Nursing, on 2/7/2025 at 1:25 P.M. The policy titled, "Enhanced Precautions for the novel and targeted MDRO's [Multi Drug-Resistant Organisms]" indicated, " ...To prevent the spread of multi drug resistant organisms [MDRO] 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 MDROs. EBP is targeted use of gown and glove use during high contact resident care activities for: Residents with wounds and indwelling devices ...." 3.1-18(a)		quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by March 3, 2025	