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	05/03/2024

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. This visit included the Investigation of Complaint IN00431936. Complaint IN00431936 - Federal /State deficiencies related to the allegations are cited at F578. Survey dates: April 29, 30, and May 1, 2 and 3, 2024 Facility number: 000017 Provider number: 155049 AIM number: 100273830 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 19 Medicaid: 44 Other: 19 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/8/24.	F 0000	May 23, 2024 Indiana Department of Health: Based upon the facility's submitted Plan of Correction and supporting documents, we would respectfully ask that consideration be given for paper compliance. Thank you, Hillary Corbitt, HFA	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hillary Corbitt	Administrator	05/23/2024

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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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to identify and clarify a change in advanced directive status related to not keeping physician	F 0578	It is the policy of Miller's Merry Manor-Warsaw to inform and provide written information to all	05/25/2024

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	orders current with a resident's advanced directive instructions for 1 of 1 resident reviewed for hospice. (Resident B) Finding includes: A record review for Resident B was completed on 4/30/2024 at 10:38 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, atrial fibrillation, and status post below the knee amputation. A Significant Change Minimum Data Set (MDS) assessment, dated 3/16/2024, indicated Resident B was cognitively intact and was receiving hospice services. Advanced Directive forms indicated the following: - An Out of Hospital Do Not Resuscitate was signed by the Medical Director on 2/9/2024. - An Indiana Physician Orders for Scope of Treatment (POST) form dated, 3/13/2024, indicated, "Do Not Attempt Resuscitation", comfort measures, use of antibiotics for infection only, and no artificial nutrition. The POST was signed by Resident B on 3/13/2024, and the facility Nurse Practitioner signed the form on 3/15/2024. - A POST form dated, 3/15/2024, indicated, "Cardiopulmonary Resuscitation" to be provided, comfort measures, use of antibiotics for infection only, and no artificial nutrition. The POST was signed by Resident B on 3/15/2024, and the hospice Medical Director signed the form on 3/27/2024. A Physician's Order dated, 2/17/2024, indicated, "Do Not Resuscitate". A Care Plan dated, 2/8/2024, indicated the code		residents upon admission concerning the right to accept or refuse medical and surgical treatment and the option to formulate advance directives. Resident B: Resident was not negatively impacted by the deficient practice. All future advance directives will be completed with accuracy. Resident B's health care representative was consulted and a new POST form was completed to reflect no CPR on 5/2/24. All residents are at risk to be affected by the deficient practice. The ADON and unit managers completed an audit on 5/9/24 and 5/13/24 of all resident charts to ensure the advance directives were accurate and signed by the physician. Advance directives will be completed upon admission and as needed when resident's condition dictate. Charge nurses will be responsible to update the advance directive with any changes made by resident, family or MD/NP as needed. The nurse managers will review resident charts to maintain accuracy with advance directives with any changes made by resident, family or MD/NP. The DON/Designee will complete the QA tool "May 2024 Survey Audit Tool" daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will	

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	status was no resuscitate. During an interview on 5/2/2024 1:06 P.M., LPN 4 indicated should Resident B's heart stop beating, or she stopped breathing, she would keep Resident B comfortable and follow her advanced directives. LPN 4 indicated Resident B had a do not resuscitate order. A policy was provided by the Director of Nursing on, 5/3/2024 at 8:02 A.M. The policy titled, "Advanced Directives", indicated, " ...[company name] will honor all advanced care planning decisions in accordance with the resident and/or representative wishes ...5 ...If the resident's preference changes, the medical record documentation will reflect this change ...." This citation relates to Complaint IN00431936. 3.1-4(f)(4)(A)(ii) 3.1-4(f)(5)		be corrected upon discovery and logged on the facility May 2024 Survey Audit Tool. Results of the audit will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or determine when to discontinue audit. (Attachment 1)	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide activities of daily living (ADL) assistance related to shaving and nail care, for 1 of 2 residents reviewed for activities of daily living. (Resident 234) Finding includes: During an observation on 4/29/2024 at 10:01 A.M., Resident 234 was observed to have long facial	F 0677	It is the policy of Miller's Merry Manor-Warsaw to cleanse and refresh resident, while providing comfort and preparing resident for the day, as well as remind or assist male residents to shave. Staff are to assure that each diabetic resident will have a weekly inspection of nails at the time of shower and or complete	05/25/2024

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	hair and long fingernails with a brown/black substance underneath them. Resident 234 indicated he did not normally have a beard, and preferred to not have a beard. He indicated his wife had requested for him to be shaved. During an observation on 5/1/2024 at 10:52 A.M., Resident 234 was observed to not have the longer beard hair, but still had significant stubble on his face. Resident 234 indicated his wife shaved him yesterday. Resident E continued to have long fingernails with the black/brown substance under the nails. A record review for Resident 234 was completed on 5/1/2024 at 12:49 P.M. Diagnoses included, but were not limited to: urinary tract infection, sepsis, quadriplegia, and diabetes mellitus type 2. An Admission Minimum Data Set (MDS) assessment dated, 4/24/2024, indicated Resident 234 had moderate cognitive impairment with impairment on both the upper and lower extremities. He required partial to moderate assistance for grooming and personal hygiene. The CNA documentation of showers in the electronic health record, dated 4/19/2024-5/1/2024, indicated Resident 234 received showers on 4/21/2024, 4/25/2024, and 4/29/2025. A Care Plan for late loss activities of daily living, dated 4/21/2024, indicated Resident 234 needed maximum assistance with dressing, grooming, and bathing. During an observation on 5/2/2024 at 10:36 A.M., Resident 234's fingernails remained long with black/brown debris under the nails and longer beard stubble.		bed bath and as needed. Resident #234: Resident was not negatively impacted by the deficient practice. Resident #234 was showered, shaved and provided nail care on 5/3/24. All male residents will be shaved. Diabetic resident's nails will be inspected and trimmed if needed weekly. All residents are at risk to be affected by the deficient practice. Licensed nurses, CNA and QMA's were re-educated on facility policy for ADL care for a dependent resident and diabetic nail care on 5/20/24 and 5/22/24. Charge nurses will be responsible for ensuring male residents are being shaved and all diabetic resident's nails will be inspected and trimmed if needed. The nurse managers will review the shower sheet daily to ensure male residents and all diabetic resident's nails are inspected and trimmed if needed. (Attachments 2, 3, and 10) The DON/Designee will complete the QA tool "May 2024 Survey Audit Tool" daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will be corrected upon discovery and logged on the facility May 2024 Survey Audit Tool. Results of the audits will be reported to QAPI monthly. The QAPI team will make recommendations to amend	

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	During an interview on 5/2/2024 at 1:13 P.M., CNA 6 indicated male residents were shaved on their scheduled shower days or when the resident requested to be shaved, and nails were evaluated for trimming on shower days. CNA 6 indicated the staff used shower sheets which indicated if shaving and nail care was provided, or a refusal occurred. The Shower Sheets were reviewed on 5/2/2024 at 2:06 P.M. Two shower sheets for Resident 234 were provided. On 4/21/2024, the shower sheet indicated Resident 234 was shaved and nail care was provided. The shower sheet on 4/25/2024 indicated no documentation of shaving or nail care. During an interview on 5/2/2024 at 2:29 P.M., LPN 3 indicated CNAs cannot trim the nails of diabetic residents. She indicated nails were evaluated when the resident was assessed daily, or when the resident was showered, the CNA would inform the nurses of the need for the nails to be trimmed. A policy was provided by the Director of Nursing on, 5/3/2024 at 8:02 A.M. The policy titled, "Morning Care", indicated, " ...To cleanse and refresh resident, while stimulating circulation and providing comfort and preparing resident for the day ...7. Remind or assist male residents to shave ...." A policy was provided by the Director of Nursing on, 5/3/2024 at 8:02 A.M. The policy titled, "Diabetic Nail Care", indicated, " ...1. Purpose: To promote cleanliness, prevent infection and skin irritation, and to promote a positive self image. To assure that each resident will have a weekly inspection of nails at the time of shower and/or		the plan of correction or determine when to discontinue audit. (Attachment 1)	

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	complete bed bath and as needed ...." 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to provide care for a central venous catheter (a long, flexible tube inserted into a large vein that leads to the heart) for 1 of 3 residents reviewed for antibiotics (Resident 234) and failed to follow physician orders for 1 of 2 residents reviewed for skin conditions non-pressure related. (Resident 236) Findings include: 1. During an observation on, 4/29/2024 at 10:01 A.M., Resident 234's central venous catheter to the right chest had a transparent dressing dated 4/19. A record review was completed on 5/1/2024 at 12:49 P.M. Diagnoses included, but were not limited to: urinary tract infection, sepsis, quadriplegia, and diabetes mellitus type 2. An Admission Minimum Data Set (MDS) assessment, dated 4/24/2024, indicated Resident	F 0684	It is the policy of Miller's Merry Manor-Warsaw to follow physician's orders and provide care and services according to professional standards of care, each resident's comprehensive care plan and resident choices. Resident #234: Resident was not negatively impacted by the deficient practice. Resident #234's central line dressing was changed on 5/2/24. Resident #236: Resident was not negatively impacted by the deficient practice. Resident #236's tubigrip was applied as ordered on 5/1/24. Licensed nurses were re-educated on central line dressing changes on 5/20/24. (Attachments 4 and 10) Biopatches are being added to the emergency med banks by pharmacy so there is stock on	05/25/2024

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	234 had intravenous access with medications administered. A Physician Order dated, 4/25/2024, indicated to change the transparent dressing to the intravenous line every 7 days and as needed if soiled or loose. A Care Plan dated 4/19/2024, indicated Resident 234 had an intravenous infusion with the potential of infection to the central line site in the right chest. On 5/2/2024 at 10:38 A.M., Resident 234's central venous catheter continued to be dated 4/19, and the transparent dressing was not adhered to the skin in the 6 o'clock position. During an interview on, 5/2/2024 at 2:30 P.M., LPN 3 indicated the central venous catheter dressing was to be changed every 7 days. She indicated the Treatment Administration Record (TAR) had been signed by the nurse on 4/25/2024 as being completed, but the facility didn't have a new bio-patch (a dressing that surrounds the central venous catheter entrance to prevent infection) in house to replace the current bio-patch when the dressing change was to be completed, so the dressing was not changed. During an observation with LPN 3 on, 5/2/2024 at 2:31 P.M., LPN 3 observed Resident 234's central venous catheter dressing and indicated the dressing was dated 4/19, and was not adhered to the skin in the 6 o'clock position. A policy was provided on, 5/3/2024 at 8:02 A.M. by the Director of Nursing. The policy titled, "VADs: [Vascular Access Devices] Ongoing Assessment, Site Care, and Dressing Changes"		hand. Nurses were also reminded to follow physician's orders and if unable to complete as written, documentation as to why is required along with physician notification when appropriate. Notification to the physician/NP is required. The DON/Designee will complete the QA tool “May 2024 Survey Audit Tool” daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will be corrected upon discovery and logged on the facility May 2024 Survey Audit Tool. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. (Attachment 1)	

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	was dated, 10/2/2017. The policy indicated, " ...Central vascular device and Midline catheter site care and dressing changes are performed every 7 days and when the integrity of the dressing is compromised, if moisture, drainage, or blood is present, or for further assessment if site infection or inflammation is suspected ...." 2. A record review for Resident 236 was completed on 5/1/2024 at 9:37 A.M. Diagnoses included, but were not limited to: cellulitis of right and left lower limb, chronic venous hypertension with ulcer and inflammation of bilateral lower extremity, peripheral vascular disease, and lymphedema. Physician Orders, dated 4/25/2024, indicated to apply single tubigrip (an elasticated tubular bandage that provides support and reduces swelling) to left lower extremity daily, on in the morning and off in the evening for wound care and lymphedema. During an observation on 5/1/2024 at 10:51 A.M., Resident 236's right lower extremity was wrapped with a compression wrap, and the left lower extremity was bare, and appeared very swollen and tight in appearance. During an observation on 5/2/2024 at 9:45 A.M., and 10:40 A.M., Resident 236's right lower extremity was wrapped with a compression wrap, and the left lower extremity was bare. The compression wrap to the right lower extremity was to remain intact. An Outpatient/Emergency Room Services Return Assessment on 4/25/2024 at 4:00 P.M., indicated Resident 236 had an appointment at the wound clinic. The assessment indicated the lymphedema had improved from the prior week, and to start the			

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	single tubigrip to the left lower extremity on the morning and off in the evening. During an interview on 5/2/2024 at 2:40 P.M., RN 5 indicated Resident 236's right lower extremity was wrapped, and those wraps were not removed. The left lower extremity had a single tubigrip placed in the morning and removed in the evening. During an observation with RN 5 on 5/2/2024 2:42 P.M., RN 5 indicated the tubigrip was on the left lower extremity. RN 5 indicated maybe the staff thought it was evening and removed the tubigrip. Resident 236 interjected and indicated the tubigrip had not been placed all day. A policy was provided by the Director of Nursing on, 5/3/2024 at 8:02 A.M. The policy titled, "New Order Transcription", indicated, " ...It is the policy of [facility name] to ensure that physician orders are transcribed and maintained in a manner that ensures safety upon administration ...." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory	F 0695	It is the policy of Miller's Merry Manor-Warsaw to provide	05/25/2024

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	equipment/tubing was properly stored when not in use and cleaned, for 2 of 4 residents reviewed for respiratory care. (Residents 46 & 62) Findings include: 1. During an observation and interview on 4/29/2024 at 9:50 A.M., Resident 42 indicated he slept in his recliner, so the continuous positive airway pressure (CPAP) machine was on top of his bed. The tubing and mask were on top of the machine uncovered. The staff had not cleaned the mask or the tubing for the past 3 months. During an observation on 4/30/2024 at 9:42 A.M., the mask and tubing were lying on the bed not covered. During an observation and interview on 5/1/2024 at 2:30 P.M., he indicated no one had cleaned his CPAP tubing or mask yesterday, it was sitting on his bed uncovered. A record review was completed for Resident 42, on 5/1/2024 at 2:16 P.M. Diagnoses included, but were not limited to: Parkinson's Disease with dyskinesia, and obstructive sleep apnea. A Physician's Order, dated 3/31/2023, indicated to disinfect tubing, mask and humidifier basin by soaking for 30 minutes in 1 part white vinegar and 4 parts water and air dry monthly, every day shift, on the last day of the month. The Treatment Administration Record (TAR), dated 4/1/2024 to 4/30/2024, indicated on 4/30/2024 during day shift the task was signed as completed. During an interview on 5/2/2024 at 8:54 A.M.,		residents needing respiratory care that is consistent with professional standards of practice, the resident's comprehensive plan of care, and per resident goals and preferences. Resident #42: Resident was not negatively impacted by the deficient practice. CPAP tubing and mask were cleaned per policy on 5/2/24 and placed in a labeled storage bag. Resident #62: Resident was not negatively impacted by the deficient practice. Nebulizer equipment was changed and placed in a labeled bag on 5/2/24. Other residents with respiratory equipment were monitored and cleaned as appropriate on 5/2/24 and placed in a labeled storage bag. Licensed nurses were re-educated on the cleaning and storage of respiratory equipment (oxygen concentrators, nebulizers, CPAP/BIPAP) on May 20, 2024. Sterile water is being purchased in bulk so ample supply is on hand for cleaning purposes. Storage bags are available in supply closets. (Attachments 5, 6, and 10) The DON/Designee will complete the QA tool “May 2024 Survey Audit Tool” daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will be corrected upon discovery and	

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(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
	QMA 7 indicated she had never washed any type of respiratory equipment, the nurses do it. She worked on 4/30/2024 with LPN 8 and LPN 8 would have cleaned the equipment for Resident 42. During an interview on 5/2/2024 at 8:59 A.M., LPN 7 indicated when she worked with a QMA, she would do the insulin injections, G-tube feedings, breathing treatments, assessments for pain, treatments for open areas, and contact the physician. She did not clean the CPAP equipment for Resident 42 on 4/30/2024. 2. During an observation on 4/29/2024 at 11:26 A.M., Resident 62's nebulizer machine was on the bed with the mask/tubing sitting on the machine uncovered. During an observation on 4/30/2024 at 9:06 A.M., the nebulizer machine was on Resident 62's bed with mask/tubing sitting on the machine uncovered. During an observation and interview on 5/2/2024 at 9:47 A.M., Resident 62 indicated she did the breathing treatments 4 times a day, the staff rinsed the equipment out once every other day. She had never had a bag for the mask before, but yesterday the nurse washed it out and said it needed to be in a plastic bag after she used it. A record review was completed for Resident 62 on 4/30/2024 at 2:33 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease with exacerbation, chronic respiratory disease with hypoxia, and bronchitis. During an interview on 5/2/2024 at 10:29 A.M., RN 2 indicated after a breathing treatment was completed, she assessed the resident, then wiped		logged on the facility May 2024 Survey Audit Tool. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. (Attachment 1)	

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	155049	A. BUILDING 00 B. WING	05/03/2024

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	the mask with a wet wash cloth, dried it and placed it in a bag, then washed the resident's face. During an interview on 5/2/2024 at 10:36 A.M., LPN 8 indicated after a breathing treatment, she would reassess the resident, listened to the lungs, and the door needed to be shut for an hour. During an interview on 5/2/2024 at 2:58 P.M., the DON indicated she would assess the patient then clean the equipment with soap and water, let it air day and place in a plastic bag. The CPAP is cleaned with vinegar and water weekly. On 5/3/2024 at 8:02 A.M., the DON provided a policy titled, "CPAP'/BiPAP." dated 4/4/2024, and indicated the policy was the one currently used by the facility. The policy indicated, "...6. Circuits are to be cleaned every week and PRN with sterile water and soap. Hang to dry. Disinfect monthly by soaking for 30 minutes in 1 part white vinegar to 4 parts sterile water. Hang to dry....." On 5/3/2024 at 8:02 A.M., the DON provided a policy titled, "High Mist Nebulizer or Oxygen Tank," dated 8/23/2012, and indicated the policy was the one currently used by the facility. The policy indicated "... 20. If desired, have the resident rinse mouth with tap water after using nebulizer. Place the nebulizer set into a plastic bag between uses. Do not rinse. Neb set is changed weekly per facility schedule....." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free			

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	from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure pharmacy recommendations were given to the physician for review, for 1 of 7 residents reviewed for unnecessary medications. (Resident 47) Finding includes: A record review for Resident 47 was completed on 5/1/24 at 3:17 P.M. Diagnoses included, but were not limited to: overactive bladder, allergies and insomnia. A Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident had intact cognition. Physician's Orders, dated 4/30/24, indicated the following:	F 0757	It is the policy of Miller's Merry Manor-Warsaw to review and forward all pharmacist recommendations to the attending physician in a timely manner. Resident #47: Resident was not negatively impacted by the deficient practice. Resident's pharmacy recommendations were completed on 5/1/24. The policy "Response to pharmacist recommendations" was reviewed with the DON by the Corporate Nurse Consultant on 5/17/24 to ensure understanding of the process. (Attachment 7). Corporate Nurse Consultant will do monthly audits x 3 to ensure timely physician notification of	05/25/2024

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	Loratidine (used for allergies) 10mg daily. Myrbetriq (used for urinary urgency/frequency) 50mg daily. Melatonin (used for insomnia) 6mg at bedtime. A Pharmacy Recommendation, dated 2/14/24, indicated Loratadine 10mg to be reduced to every other day. The recommendation lacked documentation it was acted upon in a timely manner. A Pharmacy Recommendation, dated 3/13/24, indicated Myrbetriq 50mg to be reduced to 25mg daily. The recommendation lacked documentation it was acted upon in a timely manner. A Pharmacy Recommendation, dated 3/13/24, indicated Melatonin 6mg to be reduced to 5mg at bedtime. The recommendation lacked documentation it was acted upon in a timely manner. During an interview on 5/2/24 at 11:24 A.M., the Director of Nursing (DON) indicated the new pharmacy representative for the facility was sending communication through a different portal and she was not aware, so she did not complete the recommendations in a timely manner. On 5/2/24 at 3:20 P.M., the DON provided the policy titled, "Response to Pharmacist Recommendations", dated 4/11/17, and indicated the policy was the one currently used by the facility. The policy indicated"...3. DON or designee will monitor for physician response and will re-submit to practitioner within 7 days...4. If after resending there is no response within 72 hours, the DON or designee will telephone the physician for verification the physician has reviewed the recommendation and for any new		pharmacy recommendations. Findings of audits will be submitted to the QAPI committee and the committee will determine if auditing should continue after 3 months. (Attachment 8)	

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	orders...." 3.1-48(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were kept in a locked cart when unattended for a random observation of 1 of 3 facility medication carts. (Windsor Hall cart) Finding includes:	F 0761	It is the policy of Miller's Merry Manor-Warsaw to ensure medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.	05/25/2024

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	On 5/2/24 at 10:48 A.M., the medication cart for Windsor Hall was observed with the keys in the drawer and with no licensed nursing staff within sight of the cart. The nurse left the medication cart at 10:48 A.M. and returned to the cart at 10:56 A.M. During an interview on 5/2/24 at 10:57 A.M., RN 2 indicated she heard a staff member call for help and she left the cart without taking the keys out of the lock. She was not to leave her cart unattended while unlocked and should have taken the cart keys with her. During an interview on 5/2/24 at 3:25 P.M., the Director of Nursing (DON) indicated the employee should have locked the cart and taken the keys with her, they are not to be left in the medication cart. On 5/3/24 at 8:00 A.M., The DON provided the policy titled, "Storage of Medications," dated 4/24/19, and indicated the policy was the one currently used by the facility. The policy indicated"..Medications and biological's are stored safely, securely, and properly, following manufacturers recommendations or those of supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...." 3.1-25(m)		All residents are at risk to be affected by the deficient practice. Nurse acknowledged she failed to lock the medication cart and have possession of the cart keys at all times. Licensed nurses were re-educated on locking medication and treatment carts on 5/20/24 or 5/22/24. (Attachment 10) The DON/Designee will complete the QA tool “May 2024 Survey Audit Tool” daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will be corrected upon discovery and logged on the facility May 2024 Survey Audit Tool. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. (Attachment 1)	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food brought in by outside sources and placed in resident nourishment refrigerators was stored in accordance with professional standards for food safety and used for food and beverages only, for 3 out of 4 pantry rooms reviewed. This deficient practice had the potential to affect 67 of 67 residents who reside on the units. Findings include: 1. During an observation on 5/2/2024 at 1:32 P.M., the Boulevard unit pantry had an opened container with 5 slices of cheesecake, an opened package of milk chocolate morsels, and 3 full containers of Culver's ice cream in the refrigerator without a label. 2. During an observation on 5/3/3035 at 1:36 P.M.,	F 0812	It is the policy of Miller's Merry Manor-Warsaw to ensure when resident families bring in outside food, that it is labeled with resident's name, room number and the date the food was brought into facility. All residents are at risk to be affected by the deficient practice. All ice packs will be stored in the medication room freezers. Markers and tape have been affixed to each resident refrigerator to ensure labeling supplies are readily available for staff. All nursing department staff were educated on 5/20/24 or 5/22/24 on the need to label and date all food items brought into the facility. (Attachments 9 and 10)	05/25/2024

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	the Windsor unit pantry had a large blue ice pack in the freezer compartment only. The Dietary Manager did not know why it was in there. During an interview on 5/2/2024 at 1:38 P.M., CNA 9 indicated the ice pack was used for a resident and had been placed on her hip when she asked for it. LPN 8 then indicated that was where she had always seen it placed, but it should not be in a resident refrigerator. 3. During an observation on 5/2/2024 at 1:49 P.M., the Heritage unit freezer had 3 ice packs: one large blue pack, medium size and a small one. The large blue ice pack had a bag of frozen green beans underneath it and another bag of green beans in the door shelf. During an interview on 5/2/2024 at 1:50 P.M., the Dietary Manager indicated that all food should be labeled with a date and the resident's name, and ice packs used for the Residents should not be in the pantry refrigerators on the units. On 5/2/2024 at 2:00 P.M., the Dietary Manager indicated she did not have a policy on the storage of residents' ice pack in the nourishment freezers. On 5/2/2024 at 2:00 P.M., the Dietary Manager provided a policy titled, "Resident Food From Outside Source", dated 11/28/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Family and friends are welcomes to bring food from outside source into facility for a resident. 2. Items for a resident must be labeled with name and room number and date food brought into the facility....." 3.1-21(i)(3)		The DON/Designee will complete the QA tool “May 2024 Survey Audit Tool” daily x5 days, then biweekly for 4 weeks and then monthly for a minimum of 6 months. Any identified issues will be corrected upon discovery and logged on the facility May 2024 Survey Audit Tool. Results of QA will be reported to QAPI monthly. The QAPI team will make recommendations to amend the plan of correction or discontinue audit. (Attachment 1)	