STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	200 26th St Logansport, IN 46947

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50956 Based on interview and record review, the facility failed to ensure physician's orders were followed and the physician was notified as ordered for 3 of 5 residents reviewed for quality of care. (Resident 85, 5 and 31) Findings include: 1. The clinical record for Resident 85 was reviewed on 4/23/25 at 11:21 a.m. The diagnoses included, but were not limited to, vascular dementia, major depressive disorder, anxiety disorders, hypothyroidism, hypertension, hyperlipidemia, and occlusion and stenosis of the carotid artery. A care plan, dated 1/29/25, indicated Resident 85 had chronic cardiovascular disease and hypertension. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 1/29/25, indicated to give lisinopril (a blood pressure medication) 10 milligrams (mg) daily with special parameters to hold the medication for a systolic blood pressure less than 100. A Medication Administration Record (MAR), dated 1/1/25 through 1/31/25, indicated lisinopril 10 mg was given on 1/30/25 and 1/31/25 with no blood pressure recorded at the time of administration. A MAR, dated 2/1/25 through 2/28/25, indicated lisinopril 10 mg was given daily with no blood pressure recorded at the time of administration. A MAR, dated 3/1/25 through 3/31/25, indicated lisinopril 10 mg was given daily with no blood pressure recorded at the time of administration. A MAR, dated 4/1/25 through 4/23/25, indicated lisinopril 10 mg was given daily with no blood pressure recorded at the time of administration. During an interview, on 4/23/25 at 1:57 p.m., the Director of Nursing (DON) indicated the blood pressure should have been charted on the MAR with the medication administration. During an interview, on 4/24/25 at 11:59 a.m., the DON indicated the blood pressures for Resident 85 were not recorded on the MAR at the time of administration. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/28/25 at 12:28 p.m., Unit Manager 3 indicated the resident's blood pressure should have been obtained prior to administering the medication. If the blood pressure was outside the parameter, the medication should have been held. The blood pressure would be charted in a supplemental documentation box on the MAR, charted if the medication was held. 49891 2. During an observation, on 4/21/25 at 11:16 a.m., Resident 5 was sitting in her wheelchair, wearing 2 liters of oxygen per minute, and her feet and ankles were swollen. The clinical record for Resident 5 was reviewed on 4/24/25 at 2:13 p.m. The diagnoses included, but were not limited to, chronic diastolic congestive heart failure, fluid overload, acute respiratory failure with hypoxia, paroxysmal atrial fibrillation, and chronic stage 4 (severe) kidney disease. A physician's order, dated 2/9/25, indicated to obtain a daily weight after voiding and before breakfast with same clothes, to administer an as needed (PRN) furosemide (a diuretic medication) for a weight gain of more than 3 pounds overnight, and to notify the physician of a weight gain of two (2) pounds in one (1) day and four (4) pounds in five (5) days. A physician's order, dated 2/8/25 and discontinued on 4/14/25, indicated to give furosemide 40 milligrams (mg) as needed for weight gain of more than 3 pounds overnight. A MAR, dated February 2025, indicated the following: a. On 2/21/25, the weight was 184 pounds and on 2/22/25 the weight was 187.6 pounds. This was a 3.6-pound weight gain in one (1) day. The MAR or electronic medical record did not indicate a PRN dose of furosemide was administered for the weight gain or the physician was notified. A MAR, dated March 2025, indicated the following: a. On 3/9/25, the weight was 180.8 pounds and on 3/10/25 the weight was 183.3 pounds. This was a 2.5-pound weight gain in one (1) day. The MAR or electronic medical record did not indicate the physician was notified. A MAR, dated April 2025, indicated the following: a. On 4/2/25, the weight was 184.7 pounds and on 4/3/25 the weight was 188 pounds. This was a 3.3-pound weight gain in one (1) day. The MAR did not indicate a PRN dose of furosemide was administered for the weight gain on 4/3/25. b. On 4/4/25, the weight was 191.8 pounds. This was a 3.8-pound weight gain in one (1) day. The MAR did not indicate a PRN dose of furosemide was administered for the weight gain on 4/4/25. c. On 4/5/25, the weight was 190.9 pounds. This was a 7.3-pound weight gain in five (5) days. The MAR did not indicate a PRN dose of furosemide was administered for the weight gain on 4/5/25. The MAR or electronic medical record did not indicate the physician was notified of the weight gains. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/25/25 at 2:20 p.m., LPN 2 indicated the resident would allow staff to obtain her weight each day. The resident's furosemide order had been changed from the as needed order to a routine daily order. During an interview, on 4/25/25 at 2:34 p.m., the Director of Nursing (DON) indicated the nurses should have administered the PRN diuretic medication for weight gain based on the physician's order. The nurses should have notified the physician according to the order and documented the notification in the progress notes. 3. During an observation, on 4/22/25 at 10:05 a.m., Resident 31 was in her recliner in her room with mild swelling in her ankles. The clinical record for Resident 31 was reviewed on 4/24/25 at 9:30 a.m. The diagnoses included, but were not limited to, essential primary hypertension, dementia, and type 2 diabetes mellitus with diabetic polyneuropathy. A physician's order, dated 3/25/24, indicated to administer torsemide (a diuretic medication) 40 mg as needed for a weight gain of 3 pounds in 24 hours or 5 pounds in one week. A physician's order, dated 4/5/24, indicated to obtain a daily weight after voiding and before breakfast with the same clothes and to administer the PRN torsemide medication for a weight gain of 3 pounds in 24 hours or 5 pounds in one (1) week. A MAR, dated January 2025, indicated there was no daily weight recorded on 1/16/25 and 1/25/25. A MAR, dated February 2025, indicated the following: a. On 2/10/25, the weight was 157.4 pounds and on 2/11/25 the weight was 161.6 pounds. This was a 4. 2-pound weight gain in 24 hours. The MAR did not indicate the torsemide medication was administered on 2/11/25. A MAR, dated April 2025, indicated the following: a. On 4/6/25, 4/9/25 and 4/16/25, no weight was obtained. There were no progress notes which indicated the resident refused or was unavailable. The other daily morning medications were documented as administered to the resident. b. On 4/10/25, the weight was 157.6 pounds and on 4/11/25 the weight was 161.2 pounds. This was a 3. 6-pound weight gain in 24 hours. The MAR did not indicate the torsemide medication was administered on 4/11/25. During an interview, on 4/25/25 at 2:24 p.m., RN 1 indicated the resident would let staff know when she was awake and needed her weight obtained each morning. She had a PRN torsemide medication ordered for a daily weight gain of 3 pounds or a 5-pound gain in a week which should be administered. Staff would notify the doctor based on the physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Medication Administration Procedure, dated 8/29/16 and received from the Executive Director (ED) on 4/28/25 at 10:24 a.m., indicated, .Administering Oral Medications .Complete necessary assessments before administering medications .Document initials on the administration record and any other assessment/information needed A current facility policy, titled Physician and Family Notification of Condition Changes, dated 5/14/24 and received from the ED on 4/28/25 at 10:25 a.m., indicated .Telephone notification is required for .all condition changes .Notify the physician of any change in 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. IV. Notify the primary physician during regular office hours .Document the information reported to the physician in the nurses' notes including the time and date of notification. Be thorough and explicit. VI. Document the response from the physician in the nurses' notes 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44598 Based on observation, interview and record review, the facility failed to ensure a dependent resident with a wanderguard bracelet had the placement and function checked to ensure proper working order for 1 of 1 resident reviewed for accident hazards. (Resident 29) Findings include: During an observation, on 4/21/25 at 11:51 a.m., Resident 29 walked down the second-floor hallway and sat down in a chair which faced the elevator. The resident was wearing a wanderguard bracelet (a system used to alert staff when a resident attempted to wander outside of a designated area) on her right ankle. The clinical record for Resident 29 was reviewed on 4/23/25 at 9:59 a.m. The diagnoses included, but were not limited to, dementia, overactive bladder, and hypertension. A quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, indicated Resident 29 had a severe cognitive impairment. An elopement risk assessment, dated 4/1/25 at 10:18 a.m., indicated the resident was at risk for elopement. She was independently mobile and often requested to go home. She experienced increased confusion at certain times of the day. A care plan, dated 4/1/25, indicated the resident was at risk for elopement. Interventions included, but were not limited to, check the function of the wanderguard sensor daily and check the placement of the wanderguard sensor bracelet on the right ankle. A progress note, dated 4/1/25 at 1:39 p.m., indicated the resident had been pacing the unit with her clothes packed on her walker. There was not a physician's order for the use of a wanderguard and there was no documentation the placement or function of the wanderguard was checked between 4/1/25 and 4/25/25. A Medication Administration Record (MAR), dated 4/1/25 to 4/30/25, indicated Resident 29's wanderguard placement and to monitor the function of the wanderguard was ordered on 4/25/25 and was not checked until 4/27/25. During an interview, on 4/23/25 at 3:00 p.m., Resident 29's daughter indicated that when the resident lived with her, she wandered away from the house twice and was lost. The facility had called her today and asked her to come to the facility because the resident was trying to leave and was upset. During an interview, on 4/25/25 at 2:41 p.m., the Director of Nursing (DON) indicated Resident 29 had a wanderguard. Resident 29 should have had an order for the use of the wanderguard and to check for the placement and function. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/28/25 at 10:20 a.m., Licensed Practical Nurse (LPN) 5 indicated she was the second-floor nurse and there were no residents with a wanderguard bracelet. During an interview, on 4/28/25 at 10:02 a.m., Registered Nurse (RN) 4 indicated if a resident had a wanderguard bracelet, there would be an order. The wanderguard bracelet would need to be checked every shift for placement and function and documented in the MAR. The residents would have a care plan and interventions for the wanderguard bracelet. A current facility policy, titled Elopement Risk Assessment, dated as revised 4/28/25 and received from the DON on 4/28/25 at 12:18 p.m., indicated .Identify residents at risk for elopement by completing the elopement risk assessment upon admission and with applicable significant changes in status. Residents who are identified for possible elopement will immediately have interventions placed to prevent elopement. A safety check sheet may be initiated or a wander guard alarm may be assigned to resident .When appropriate, or based upon the results of the elopement risk assessment, a wander guard bracelet will be applied to residents to alert staff when residents are attempting the leave the facility unattended .Nursing staff will check for placement of the wander guard bracelet each shift and document on the treatment record . Nursing staff will check the sensors daily using the sensor check device or by taking the resident over the door mat and document on the treatment record 3.1-45(a)(2)