STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morristown Manor	868 S Washington St Morristown, IN 46161

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34850 Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document whether self-administration of medications was clinically appropriate for 1 of 8 residents observed during medication administrations. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed on 5/21/25 at 9:00 a.m. The diagnoses included, but were not limited to, hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident was cognitively intact. A physician's order, dated 1/7/25, indicated the resident was to receive 400 milligrams (mg) of magnesium oxide twice a day. A physician's order, dated 11/5/21, indicated the resident was to receive 240 mg of diltiazem (blood pressure medication) once a day. A physician's order, dated 4/13/22, indicated the resident was to receive a calcium supplement once a day. A physician's order, dated 9/13/24, indicated the resident was to receive carboxymethylcellulose sodium eye drops once a day. A physician's order, dated 5/6/25, indicated the resident was to receive 12.5 mg of metoprolol (blood pressure medication) twice a day. The staff was to obtain resident's heart rate and ordered to hold the medication if her heart rate was less than 60 beats per minute. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted of a medication administration for Resident 52 with Qualified Medication Aide (QMA) 2 on 5/21/25 at 9:10 a.m. QMA 2 was observed preparing Resident 52's medications at the medication cart. She had pulled the following tablets: 400 mg of magnesium, 12.5 mg of metoprolol, oyster shell calcium supplement, and 240 mg of diltiazem. She then went to the resident's room to administer the medications. QMA 2 was observed obtaining the resident's heart rate and administering the resident's eye drops. The resident's cup of medications was placed on the bedside table. After, QMA 2 walked to the doorway prior to the resident picking up the medication cup of pill medications. The resident was not observed taking the pill medications. An interview was conducted with QMA 2 on 5/21/25 at 9:35 a.m. She indicated Resident 52 was able to take her medications without supervision. An interview was conducted with the Director of Nursing (DON) on 5/22/25 at 9:22 a.m. She indicated Resident 52 had not been assessed to determine if she could safely administer her medications herself. A bedside medication and self-administration of medications policy was provided by the DON on 5/22/25 at 9:44 a.m. It indicated, .Each resident who desires to self-administer medication will be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. Procedure. 1. Each resident is offered the opportunity to self-administer his/her medications during the routine assessment by the facility's interdisciplinary team (IDT). 2 .If the resident desires to self-administer medication, an assessment is conducted by the IDT of the resident's cognitive, physical and visual ability to carry out this responsibility .3. Cognitive ability should be the initial assessment to determine if a resident is capable of self-medicating. It is recommended that the Mini-Mental Status Examination or similar screening tool be used. Once cognitive status is established, the resident requires a skills assessment. 4. The IDT determines the residents ability to self-administer medications by means of a skill assessment as follows: a) The resident's medications are obtained from the pharmacy by usual means. b) The resident is instructed in the use of the package, purpose of the medication, reading of the label and scheduling of medication doses. c) The resident is then requested to read the label on each package and indicate at what time the medication should be taken, and any other special instructions for use. d) The resident is asked to demonstrate the removal of the medication from the package 3.1-11(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51750 Based on observation and interview, the facility failed to ensure a resident's call light was within reach for 1 of 1 resident reviewed for environment. (Resident 11) Findings include: On 5/20/25 11:18 a.m., an observation of Resident 11's room revealed as the resident sat in her wheelchair, her call light was not within reach as it laid across her bed. During an observation of Resident 11 in her room on 5/21/25 10:37 a.m., the resident's call light was between the wall and the resident's bed, not within reach, as she sat in her wheelchair. During an interview on 5/21/25 10:39 a.m., the Social Services Director (SSD) indicated Resident 11's call light should be within her reach. On 5/22/25 at 3:44 p.m., the Director of Nursing (DON) indicated the facility did not have a policy specific to the use of call lights. 3.1-3(v)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40287 Based on interview and record review, the facility failed to timely update a care plan with new interventions for behavior management for 1 of 3 residents reviewed for dementia care (Resident 69). Findings include: The clinical record for Resident 69 was reviewed on 5/21/25 at 10:36 a.m. The diagnoses included, but were not limited to, dementia with mood disturbance and paranoid mood disorder. A care plan, with a start date of 9/6/24 and last revised 5/6/25, indicated she had physically abusive behavioral symptoms and violent behaviors such as grabbing another resident's shirt and arm, and hitting staff during care. The goal was for her not to be physically abusive to other residents, visitors, and/or staff. The interventions, which were initiated on 9/6/24, included but were not limited to, administering medications as ordered by the physicians, avoid over-stimulation, convey an attitude of acceptance towards her, and divert her behavior by offering an activity. A Quarterly Minimum Data Set (MDS) assessment, completed 3/10/25, indicated she was moderately cognitively impaired and had displayed verbal behaviors toward others and wandering behaviors for one to three days during the assessment period. A progress note, dated 3/9/25 at 7:50 p.m., indicated Resident 69 seemed mad at the staff and was making comments towards staff as if they had said something to her and argued with staff. Resident 69 had indicated she was leaving and attempted to leave the building through the dining room door. A staff member had been able to redirect her to her room. A social service progress note, dated 3/10/25 at 6:22 a.m., indicated Resident 69 had exhibited cursing, screaming, exit seeking, and false beliefs on 3/9/25. Staff attempted to redirect, provide one on one attention, offered food and fluids, provided a calm environment, and ensured Resident 69's safety. Staff had attempted meaningful activities and a back rub. The interventions were not effective. The Intradisciplinary Team (IDT) had met and reviewed behaviors. Staff were to continue to redirect Resident 69 as needed, offer reassurance and validation, and provide walks for Resident 69 if needed. The behavior care plan had not been updated to reflect the attempt to exit the facility or new interventions to address the behavior. A social service progress note, dated 3/12/25 at 6:17 a.m., indicated, on 3/12/25 at 2:05 a.m., Resident 69 was wandering about the unit. The staff had tried to redirect but it was not effective. The IDT team had met and reviewed the behavior. Staff were to redirect Resident 69 as needed and the resident was placed on fifteen-minute checks. The behavior care plan had not been updated with the new intervention of fifteen-minute checks. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 3/20/25 at 4:57 p.m., indicated Resident 69 had displayed increased aggressive behaviors and exit seeking. The Nurse Practitioner (NP) was informed and a new order for medication changes had been received. A social service progress note, dated 3/21/25 at 6:06 a.m., indicated Resident 69 had been wandering on 3/20/25 at 3:42 p.m. Staff had redirected with food and fluids, and the intervention was effective. On 3/20/25 at 4:30 p.m., Resident 69 began pacing and threatening staff. Resident 69 had displayed false beliefs and misperceptions and threatened to hit staff. Staff had attempted redirection, and it was not effective. The IDT team had met and reviewed behaviors. Staff would continue to redirect Resident 69 as needed. Resident 69's Depakote (anti-convulsant medication used to stabilize mood) was increased. A progress note, dated 4/10/25 at 1:13 p.m., indicated the Psychiatric NP and Proactive NP had been made aware of the urinalysis results and possible room move to the secured unit. A social services progress note, dated 4/11/25 at 2:36 p.m., indicated the nursing staff had spoken with Resident 69's daughter about moving Resident 69 to the secured dementia unit. Verbal consent had been received to move Resident 69. A progress note, dated 4/11/25 at 3:22 p.m., indicated Resident 69 has been relocated to the secured dementia unit. The behavior care plan had not been updated with the new intervention of relocating Resident 69 to the secured dementia unit. During an interview on 5/22/25 at 1:54 p.m., Social Service Director 1 indicated staff had tried many non-pharmalogical interventions with Resident 69 such as walking with her, back rubs, validating her feelings, and offering snacks. During an interview on 5/22/25 at 1:54 p.m., the Director of Nursing indicated Resident 69 had displayed exit seeking behavior and had begun wandering more. There had been a change in Resident 69's cognition, and she had become very focused on leaving the building. She was not always able to communicate her wants or feelings and could become agitated very quickly with little warning. There had been labs done and many attempts to redirect and calm Resident 69. There was another resident in the facility who seemed to exacerbate Resident 69's behavior. The facility had somewhat generalized care plans and Resident 69's care plans could be more individualized. During an interview on 5/22/25 at 3:13 p.m., the Director of Nursing indicated the facility did not have a specific care plan policy but followed the Resident Assessment Instrument Manual. On 5/22/25 at 8:42 a.m., the Director of Nursing provided the Behavioral Health Management Program Policy, dated January 2024, which indicated .[Name of Facility Corporation] believes in a person-centered care approach and tailors all considerations for the individual affected, including physical and psychosocial aspects of wellbeing when it comes to managing maladies that manifest behavioral disturbances . 3.1-35(b)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51750 Based on interview and record review, the facility failed to monitor the use of a non-invasive ventilator (NIV) for 1 of 1 resident reviewed for respiratory care. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed on 5/21/25 11:10 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and hypoxemia (low levels of oxygen in the blood). A Quarterly Minimum Data Set (MDS) assessment, completed 2/11/25, indicated Resident 11 was cognitively intact. A care plan, initiated on 11/18/2020, indicated Resident 11 had a diagnosis of sleep apnea and was at risk for respiratory difficulties or distress. The goal was for the resident to have no related complications through the next review related to sleep apnea diagnosis. Interventions included, but were not limited to, apply the NIV machine as ordered and to list settings, monitor oxygen saturation levels and apply oxygen as ordered, and contact physician as needed. A physician's order, dated 4/14/25, indicated the NIV to be applied at bedtime and instructed the use of specific settings of the machine. Staff were to monitor and document respiratory rate, minute volume, exhaled tidal volume, and resident tolerance. A review of the Medication Administration Records (MARs) and the Treatment Administration Records (TARs) was conducted on 5/21/25 11:21 a.m. The MARs and TARs did not contain documentation of monitoring with the use of the NIV, as ordered. An interview was conducted, on 5/21/25 at 2:10 p.m., with the Director of Nursing (DON). She indicated the order set was put in on the respiratory flowsheet, which was unseen by nursing. Therefore, there was no documentation of the treatment recorded. On 5/22/25 at 3:31 p.m. the DON provided the Non-Invasive Ventilation Policy, last revised 12/2022, which indicated .Respiratory and/or nursing personnel trained to perform and care for the Non-Invasive Ventilation dependent resident will perform equipment setup, monitoring, and troubleshooting as per physician order . 24. Document procedure in resident's medical record (date and time, concerns and action taken, resident's tolerance of procedure, respiratory assessment (breath sounds, oxygen saturation, pulse rate and respiratory rate) and type of Non-Invasive ventilation . 3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34850 Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by utilizing hand hygiene during medication administrations for 3 of 8 residents observed during medication administrations. (Resident 50, Resident 52, and Resident 85) Findings include: 1. The clinical record for Resident 50 was reviewed on 5/21/25 at 8:40 a.m. The diagnoses included, but were not limited to, vascular dementia. An observation was conducted of a medication administration for Resident 50 with Qualified Medication Aide (QMA) 2 on 5/21/25 at 8:40 a.m. QMA 2 was observed preparing the resident's medications at the medication cart. She had pulled all pill medications from the drawers and utilized scissors to cut the storage packaging of the pill medications. She then dropped the pill medications in a medication cup. During that time, she had donned gloves to touch a pill medication. After doffing her gloves, she crushed the pill medications; grabbed a spoon from a plastic storage bag and mixed the pill medications in pudding. She then administered the medications to the resident in the dining room. During the preparation of the pill medications, QMA 2 was observed touching scissors, storage bag of unwrapped spoons, drawers of the medication cart, and computer mouse. There was no observation of QMA 2 utilizing hand hygiene prior to donning and doffing gloves or prior to the administration of the medication to the resident. 2. The clinical record for Resident 52 was reviewed on 5/21/25 at 9:00 a.m. The diagnoses included, but were not limited to, hypertension. An observation was conducted of a medication administration for Resident 52 with QMA 2 on 5/21/25 at 9:10 a.m. QMA 2 was observed preparing Resident 52's medications at the medication cart. During that time, she touched the computer mouse, pill packets, a pill medication, scissors, medication drawers, and a storage bag of unwrapped spoons. She then went to the resident's room to administer the medications. QMA 2 was observed donning on gloves, administering eye drops, and touching the resident's face. She then doffed her gloves and left the room. There was no observation of hand hygiene prior to leaving the medication cart and donning her gloves. 3. The clinical record for Resident 85 was reviewed on 5/21/25 at 9:26 a.m. The diagnoses included, but were not limited to, vascular dementia. An observation was conducted of a medication administration for Resident 85 with QMA 2 on 5/21/25 at 9:26 a.m. QMA 2 was observed preparing the pill medications at the medication cart. She pulled all medications including a medication patch. During that time, she was observed touching pill packets, the computer mouse, medication drawers, pen, and medication patch. After, she entered the resident's room. QMA 2 was observed donning gloves and applied a new medication patch on the resident's back. After the administration of the pill medications and medication patch, she left the room. There was no observation of hand hygiene prior to administration of the medication patch and donning gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with QMA 2 on 5/21/25 at 9:35 a.m. She indicated she utilized hand hygiene prior to pulling the medications and after the administration to the resident. She should have utilized hand hygiene prior to donning gloves. An interview was conducted with the Infection Preventionist on 5/22/25 at 10:17 a.m. She indicated the staff should utilize hand hygiene before the preparation of the medications and prior to leaving the medication cart to administer the medication to the resident. A medication administration policy was provided by the Director of Nursing on 5/22/25 at 9:03 a.m. It indicated, .5. Bring medication cart to an area adjacent to resident room .7. Wash hands before medication pass .8. Remove medication from drawer, read label when taking from drawer and before putting in medication cup or pouring liquids .19. Cart was locked .Gel hands 21. Knock on resident's door before entering residents room . 3.1-18(l)