STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366031	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Manor Care Center	983 Exchange St Vermilion, OH 44089

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure residents receiving psychotropic medications were adequately monitored for effectiveness and adverse reactions. This affected five (#1, #3, #11, #19, and #22) of five residents reviewed for unnecessary medications. The facility census was 23.Findings Include: 1. Review of the medical record for Resident #1 revealed an admission date of 06/03/25 and a discharge date of 11/20/25. Diagnoses included type two diabetes mellitus, hypertension, gastro-esophageal reflux disease, Parkinson's disease, major depressive disorder, and anxiety. Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Review of Resident #1's physician orders dated 06/03/25 revealed orders for Prozac (an antidepressant) 40 milligrams (mg) daily for depression related to major depressive disorder and Buspar (an antianxiety medication) 100 mg twice daily for depression related to major depressive disorder. Review of Resident #1's care plan dated 06/05/25 revealed the resident used psychotropic medications to manage depression and for behavior with depressive features. Interventions included to monitor for changes in cognition, mood, and behaviors. Review of nursing progress notes dated 06/03/25 through 11/20/25 for Resident #1 revealed no documentation of monitoring for adverse effects or effectiveness of the medications Prozac or Buspar. Review of Resident #1's medication administration records (MARs) dated 06/03/25 through 11/20/25 revealed no documentation the resident received monitoring for the effectiveness and adverse effects for the use of the medications Prozac or Buspar. 2. Review of the medical record for Resident #11 revealed an admission date of 02/26/25. Diagnoses included chronic obstructive pulmonary disease, pneumonia, hypoxemia, acute respiratory failure with hypoxia, encephalopathy, cognitive communication deficit, hyperlipidemia, anxiety, neurocognitive disorder with Lewy bodies, hypothyroidism, hypertension, syncope and collapse, hypertensive chronic kidney disease, osteoarthritis, depression, repeated falls, and cardiac arrythmia. Review of the MDS assessment dated [DATE] revealed a BIMS score of 11, indicating Resident #11's cognition was moderately impaired. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's physician orders dated 02/25/25 revealed an order for Ativan (a benzodiazepine) 0.5 mg in the evening for anxiety and Trazodone (an antidepressant) 25 mg at bedtime for insomnia. Review of nursing progress notes dated 02/26/25 through 01/06/26 for Resident #11 revealed no documentation of monitoring of adverse effects or effectiveness of the Ativan or Trazodone. Review of Resident #11's MARs dated 02/26/25 through 01/06/26 revealed no documentation of monitoring of adverse effects or effectiveness of Ativan or Trazodone. 3. Review of the medical record for Resident #22 revealed an admission date of 08/30/24. Diagnoses included major depressive disorder, dementia, restlessness and agitation, anxiety disorder, cognitive communication deficit, Alzheimer's disease, difficulty in walking, and generalized muscle weakness. Review of Resident #22's physician orders dated 08/30/24 revealed an order for escitalopram (an antidepressant) 5 mg every morning for depression and Risperdal (an antipsychotic) 0.5 mg twice daily for dementia. Review of Resident #22's care plan, with a revision date of 12/23/25, revealed the resident used psychotropic medications to manage depression and for behavior with depressive features. Interventions included to monitor for changes in cognition, mood, and behaviors. Review of nursing progress notes dated 08/01/25 through 01/06/26 for Resident #22 revealed no documentation of monitoring of adverse effects or effectiveness of escitalopram or Risperdal. Review of Resident #22's MARs dated 08/01/25 through 01/06/26 revealed no documentation the resident received monitoring for the effectiveness or adverse effects of escitalopram or Risperdal. 4. Review of the medical record for Resident #3 revealed an admission date of 09/05/24. Diagnoses included type two diabetes mellitus, depression, insomnia and anxiety. Review of Resident #3's MDS assessment dated [DATE] revealed Resident #3 was cognitively intact. Review of Resident #3's physician orders dated 08/18/25 revealed an order for Zoloft (an antidepressant) 100 mg by mouth in the morning for depression. Review of Resident #3's care plan dated 09/05/24 revealed Resident #3 had ineffective individual coping skills as evidence by demanding behavior. Interventions included to monitor behavior and notifying the physician of concerning changes. Further review of Resident #3's care plan revealed the facility had no monitoring of antidepressant medication effects. Review of Resident #3's MARs dated 09/01/25 through 01/06/26 revealed no documentation the resident was monitored for effectiveness and adverse effects for the use of the medication Zoloft. 5. Review of the medical record for Resident #19 revealed an admission on [DATE]. Diagnoses included disorder of the autonomic nervous system, major depressive disorder, and anxiety disorder. Review of the MDS assessment dated [DATE] revealed Resident #19 was cognitively impaired. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's physician order dated 11/11/25 revealed an order for duloxetine (an antidepressant) 100 mg by mouth in the morning for depression, and an order dated 12/04/25 revealed an order for buspirone (an antianxiety medication) 5 mg with instructions to give 7.5 mg by mouth in the afternoon and evening for anxiety. Review of the care plan dated 02/23/24 revealed Resident #19 had ineffective individual coping skills as evidence by a lowered self-esteem and social isolation. Interventions included observing behavior and notifying the physician of concerning changes. Further review of the care plan revealed Resident #19 required psychotropic medication to manage depression, behavior with depressive features, and anxiety. Interventions included evaluating the effectiveness and side effects of medication and monitoring for changes in cognition, mood, and behaviors. Review of Resident #19's MARs dated 09/01/25 through 01/06/26 revealed no documentation the resident was monitored for effectiveness and adverse consequences and effectiveness of duloxetine or buspirone. Interview on 01/06/25 at 8:30 A.M. with Licensed Practical Nurse (LPN) #318 revealed the facility does not routinely monitor residents who are prescribed psychotropic mediations for effectiveness and adverse consequences. Interview on 01/06/25 at 11:42 A.M. with LPN #327 revealed the facility does not monitor residents daily who are prescribed psychotropic medications and adverse consequences. LPN #327 stated the facility nurses know what to look for and do not document unless there was an issue. Interview with Assistant Director of Nursing (ADON) #327 on 01/06/26 at 11:42 A.M. confirmed the facility did not have any documentation for daily monitoring of psychotropic medications, including for Resident #1, Resident #3, Resident #11, Resident #19, and Resident #22. ADON #327 stated the nurses knew the adverse effects but do not document unless there was an issue. Further interview with ADON #327 revealed the facility had no policy regarding the monitoring of psychotropic medications. Review of the facility policy titled, Psychotropic Medications, dated May 2024, revealed no guidelines in place for monitoring side effects, adverse effects, and medication effectiveness.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to implement physician order changes identified during a medication regimen review (MRR). This affected one (#19) of five residents reviewed for unnecessary medications. The facility census was 23.Findings include:Review of the medical record for Resident #19 revealed an admission on [DATE]. Diagnoses included unspecified intestinal obstruction, constipation, and hypothyroidism. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively impaired.Review of Resident #19's medication regimen review (MRR) signed and dated by the physician on 11/06/25 revealed an note to change the stool softener, docusate sodium 100 milligrams (mg) to be administered as needed.Review of Resident #19's physician orders dated 11/11/25 revealed an order for docusate sodium 100 milligrams (mg) with instructions to give one tablet by mouth two times a day. Review of Resident #19's medication administration records (MARs) dated 11/01/25 through 01/06/26 revealed Resident #19 received docusate sodium 100 mg two times a day. Interview on 01/06/25 at 10:40 A.M. with the Director of Nursing (DON) confirmed the physician wrote to change Resident #19's docusate sodium 100 mg order to as needed, and further confirmed the medication was given twice a day from 11/01/25 through 01/06/26. The DON further stated she spoke to Licensed Practical Nurse (LPN) #321 who originally discontinued the medication on 11/11/25, then placed the order back in Resident #19's orders on 11/11/25 as a twice daily order, and confirmed it was done in error. Further interview with the DON revealed the facility did not have a policy on transcribing or following physician's orders.