STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	505 N Bradner Ave Marion, IN 46952

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on record review, staff interview, and facility policy review, the facility failed to ensure the Activities Program was directed by a qualified professional who met required training and certification standards prior to assuming the role of Activities Director. This failure had the potential to affect 69 of 69 residents who relied on the activities program to meet their psychosocial, emotional, and social needs. Findings include:During a review of employee records on 12/31/25 at 8:40 a.m., records indicated the Activities Director (AD) lacked the required training and/or certification for the position. The records lacked evidence of completion of an approved activities training course or documentation demonstrating qualifications consistent with regulatory requirements at the time the individual was hired into the position.During an interview with the AD on 1/6/25 at 9:52 a.m., she indicated she had been in the position since 12/1/25. Prior to becoming the AD, she was the assistant to the AD. There was no training required to be the assistant. After being hired as the AD, she signed up for online training. At the time of the interview, she was awaiting notification of a start date from the online program. During that waiting period, she continued to schedule activities like those of the previous AD.During an interview with the Administrator on 12/31/25 at 3:00 p.m., she indicated the AD's start date was 12/1/25. Both she and the AD were awaiting notification from the training program about a start date for the training. A current facility policy, titled Activity Director or Director of Life, provided by the administrator on 1/6/26 at 9:00 a.m., indicated the following: .Requirements/Qualifications: Therapeutic recreation specialist who is: 1. Licensed or registered, if applicable, by the State in which practicing. 2. Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized, accrediting body. 3. Has two (2) years' experience in a social or recreational program within the last five (5) years, one of which was full-time in a patient activities program in a health care setting. 4. Is a qualified occupational therapist or occupational therapy assistant.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	505 N Bradner Ave Marion, IN 46952

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. A. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies for draining venous wounds to mitigate risk of contamination to the wounds and the risk of exposure to bodily fluids for others for 1 of 4 residents reviewed for pressure injuries. (Resident 64) B. Based on observation, interview and record review, the facility failed to maintain foley catheter tubing and drainage bags in a sanitary manner for 2 of 2 residents reviewed for foley catheters. (Residents 68 and 82) Findings include:A. During an observation, on 12/29/25 at 11:09 a.m., Resident 64 shuffled out of her room, using a two-wheel walker and wearing nonskid socks. Resident 64's clinical record was reviewed on 12/31/25 at 9:21 a.m. Diagnoses included old myocardial infarction (heart attack), generalized edema, atherosclerotic heart disease of the native coronary artery without angina pectoris, chronic obstructive pulmonary disease, altered mental status, dementia, lymphedema, and peripheral vascular disease. Current orders included the following: Wash both lower legs with normal saline or wound cleanser, pat dry, apply Xeroform (non-adhering wound treatment dressing), cover with alginate (wound treatment), wrap with gauze wrap or bordered silicone dressing daily and as needed for wound care (12/31/25) and cleanse left foot with normal saline or wound cleanser to the third toe area, pat dry, apply xeroform, cover with alginate, wrap with gauze wrap daily and as needed for soilage/dislodgement until healed (1/2/26). A quarterly Minimum Data Set (MDS) assessment, dated 10/10/25, indicated the resident was severely cognitively impaired. She had no behaviors during the assessment period. She required supervision/touching staff assistance for ambulation. She required set up and cueing for upper and lower body dressing. She was dependent on staff assistance for putting on/taking off footwear. A current care plan, initiated on 5/12/25, for wounds indicated that the resident was admitted with wounds that were potentially related to peripheral vascular disease with recurring areas to both lower extremities. Open areas to both lower extremities were nonhealing. Resident 64 frequently removed treatments after they were applied, declined lower extremity elevation, and family declined intervention for vascular insufficiency and chose to opt for comfort care. Interventions included administer treatment as ordered (5/12/25). A current care plan was initiated on 12/30/25 for a denuded (top layer of skin is gone) blister to left foot second toe. Interventions included treatment as ordered (12/30/25). A current care plan for edema, initiated on 1/23/25, indicated the resident had edema to her lower extremities with a potential for weight fluctuations. Both her lower extremities had breaks in the skin and were seeping. She removed the treatments from her lower extremities due to her preference for comfort. Interventions included administer treatment to right shin as ordered and encourage resident to leave dressing on. Staff had noted she removed the dressings (6/14/25). A current care plan for falls, initiated 1/23/25, indicated the resident was at risk for falls due to her condition and risk factors of unsteadiness, impaired mobility, diagnosis of dementia, chronic pain in both lower extremities, fluctuations in shuffling gait. Resident refused to apply nonslip socks and slippers at times. Interventions included encourage and assist with wearing non-skid footwear (3/31/25) and encourage the use of slippers (9/17/25). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	505 N Bradner Ave Marion, IN 46952

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 12/31/25 at 11:23 a.m., Resident 64 shuffled, using a two-wheel walker, down the hall, then sat in a chair. Her legs and feet were swollen. She wore nonskid socks. During an observation, on 1/2/26 at 9:38 a.m., CNA 3 walked by Resident 64 as the resident shuffled, barefoot, using a two-wheel walker, down the hall on the unit. Her left pant leg was pulled up to her left knee. Three wounds with a small amount of serosanguineous (watery, bloody) drainage were open to air. The top wound had a line of serosanguineous drainage trailing down her leg about length of the diameter of a soup can. She had an open area to her left third toe near the foot. The end of the left foot third toe around toenail was swollen with a greenish tinge. The area had a wet appearance. During an observation, on 1/2/26 at 9:53 a.m., QMA 4 walked by Resident 64 as Resident 64 shuffled, barefoot, using a two-wheel walker, down the hall on the unit. Resident 64 entered Resident 70's room. She shuffled around the room and came back out. Her left pant leg remained pulled up, with draining wounds on her left leg and left foot third toe exposed. During an observation, on 1/2/26 at 10:15 a.m., the Wound Nurse assisted the resident to sit on the edge of the bed. The wounds continued to be visible, open, and draining a small amount of serosanguineous fluid with a line trailing from the top open area down her leg. During a wound care observation, on 1/2/26 at 10:19 a.m., the three wounds to the resident's left leg were cleansed and Xeroform, calcium alginate, and a bordered silicone dressing was applied by the Wound Nurse. She indicated, at the same time, the wounds were draining. The soles of the resident's feet were dirty and darkly soiled. The Wound Nurse put a nonskid sock on the resident's dirty right foot. She cleaned the resident's left foot, then cleansed the left third toe. The area to the left third toe had a darkened brown/black area at base of the toe. The area surrounding the nailbed and down the toe, about length of the diameter of a triple A battery, was swollen with a greenish color. The back of the toe had a darkened center with pale skin surrounding it. The area was draining a scant amount of yellowish drainage. The Wound Nurse applied Xeroform, calcium alginate, and a bordered silicone dressing to the toe. She put a clean nonskid sock on the resident's left foot. She indicated, at the same time, she should have washed the resident's left foot prior to putting on the nonskid sock. The resident often removed her wound dressings. The resident should not walk around the unit with the wounds draining without the wounds being covered. During an interview, on 1/2/25 at 3:36 p.m., QMA 4 indicated if a resident was walking around barefoot, she would make sure the resident was assisted to put on nonskid footwear. When a resident had open, draining wounds on legs and feet, she would make sure their legs and feet were wrapped or covered. During an observation, on 1/2/25 at 3:45 p.m., Resident 64 was lying on Resident 70's bed with nonskid socks on her feet. During an interview, on 1/2/25 at 3:54 p.m., QMA 5 indicated residents should wear proper footwear, and she would assist them as needed to put on their footwear. If a resident was walking around with draining wounds, she would notify the nurse immediately for proper treatment. The Nurses Notes in the resident's clinical record lacked documentation of the resident removing her dressings to her legs or her footwear on 1/2/25. During an interview, on 1/5/25 at 9:45 a.m., the DON indicated the ultimate goal would be for Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	505 N Bradner Ave Marion, IN 46952

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	64 to have a dressing on her wounds, but the resident did at times remove them. If the dressings were removed, then the staff should redirect the resident away from other residents, and some sort of barrier should be attempted to be placed on the draining wounds. According to the Centers for Disease Control and Prevention (CDC) website, accessed on 1/6/25 at https://www.cdc.gov/infection-control/hcp/isolation-precautions/precautions.html#cdc_generic_section_2-iii-a-s .Standard Precautions combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. A current facility policy, dated 6/11/25, titled Standard Precautions, provided by the Administrator on 1/5/25 at 10:19 a.m., indicated the following: .Standard Precautions are work practices that provide a basic level of infection control for the care of all patients in health care facilities regardless of their diagnosis or presumed infection status. 1. Standard Precautions (Minimum Precautions) apply to: a. Blood b. All body fluids, secretions and excretions except sweat regardless whether they contain visible blood c. Non-intact skin d. Mucous membranes 2. Standard Precautions are designed to reduce the risk of transmission of micro-organisms from both recognized and un-recognized sources of infection. They include: . b. Use of protective barriers, which may include gloves, gowns, plastic aprons, masks, eye shields or goggles. B1. During an observation, on 12/29/25 at 10:42 a.m., Resident 82 was observed sitting in her wheelchair. Her foley catheter tubing was lying on the floor beneath her wheelchair. During an observation, on 12/31/25 at 10:52 a.m., Resident 82 was observed participating in physical therapy. She sat in her wheelchair with her foley catheter bag underneath her wheelchair in a privacy bag. Half of the privacy bag touched the floor. A therapy staff member started propelling Resident 82 out of the therapy room and down the hallway toward Resident 82's room. The foley catheter bag was still attached to the underside of the resident's wheelchair. The privacy bag was dragging on the floor as Resident 82 was propelled down the hallway. During an observation, on 12/31/25 at 11:17 a.m., Resident 82 sat in her recliner with her legs elevated. Her foley catheter bag was lying on the floor to the right side of her recliner. During an interview, on 12/31/25 at 11:18 a.m., LPN 7 indicated foley catheter bags or tubing should not touch the ground. LPN 7 proceeded to attach Resident 82's foley catheter bag to the resident's walker, which was beside her recliner. On 12/31/25 at 11:23 a.m., CNA 8 indicated she had assisted Resident 82 into her wheelchair. CNA 8 was unable to attach the foley catheter bag to Resident 82's recliner, so she placed the foley catheter bag between the recliner and leg rest. Resident 82's clinical record was reviewed on 12/31/25 at 2:16 p.m. Diagnoses included right femur fracture and history of falls. Current orders included catheter care every shift and ensure catheter drainage bag is below the waist and covered, change as needed for leakage or dislodgement, change catheter drainage bag at the time of catheter change and enhanced barrier precautions during high contact resident care. A current care plan, initiated 12/24/25, indicated Resident 82's catheter would be maintained per plan (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	505 N Bradner Ave Marion, IN 46952

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care daily and she would remain free from catheter related complications daily such as leakage or infection. Interventions included catheter care every shift and provide measures to prevent excessive pulling/ tension on the catheter tubing. During an interview, on 1/5/26 at 9:43 a.m., the DON indicated the foley catheter bag should be hanging below the resident's bladder. The foley catheter bag, tubing, and privacy bag should not touch the floor. B2. During an observation, on 1/6/26 at 1:01 p.m., Resident 68 was in her room sitting in her wheelchair. Her foley catheter was attached under her wheelchair with the foley catheter tubing lying on the floor. During an interview, on 1/6/26 at 1:03 p.m., RN 10 indicated Resident 68's foley catheter tubing should not touch the floor. RN 10 put on gloves before picking up Resident 68's foley catheter tubing and securing it inside the foley catheter privacy bag that was attached on the underneath side of Resident 68's wheelchair. Resident 68's clinical record was reviewed on 1/6/26 at 1:38 p.m. Diagnoses included urinary tract infections. Current orders included catheter care every shift and ensure catheter drainage bag is below the waist and covered, change as needed for leakage or dislodgement, change catheter drainage bag at the time of catheter change and cefpodoxime proxetil (antibiotic) 200 milligrams twice daily for urinary tract infection. A current care plan, initiated 1/2/26, indicated Resident 68's catheter would be maintained per plan of care daily and she would remain free from catheter related complications daily such as leakage or infection. Interventions included catheter care every shift and provide measures to prevent excessive pulling/ tension on the catheter tubing. A current facility policy, dated 8/30/07, titled Foley Catheter Care and Maintenance, provided by the Administrator, on 1/6/26 at 9:12 a.m., indicated the following: .E. Placement of Catheter Tubing Procedure. C. Ensure bag or tubing is not touching the floor 3.1-18(a)