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	04/10/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and record review, the facility failed to document how a resident's behaviors presented a danger or distress to the resident or others or the non-pharmaceutical interventions used to treat the behaviors which had failed prior to the addition of new mental diagnoses and antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 6)Findings include:The clinical record for Resident 6 was reviewed on 4/9/26 at 10:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, borderline personality disorder, delusional disorder, schizoaffective disorder, and depression. A preadmission screening and resident review (PASSAR), dated 3/7/25, indicated Resident 6 had diagnoses of depression and dementia and was taking sertraline (a medication used to treat depression). An admission minimum data set (MDS) assessment, dated 3/17/25, indicated Resident 6 had a severe cognitive impairment, the diagnoses of Alzheimer's disease and depression, and was treated with an antidepressant medication.A nursing progress note, dated 4/27/25 at 1:21 p.m., indicated Resident 6 had indicated there were two men causing trouble and bothering her and her neighbor (the room next door). Resident 6 stated these two men were Siamese and made high pitch whistle sounds.A nursing progress note, dated 5/8/25 at 7:08 p.m., indicated Resident 6 thought there was a man in her room today.A nursing progress note, dated 5/14/25 at 9:20 p.m., indicated Resident 6 refused all her evening medications.A nursing progress note, dated 5/16/25 at 9:13 p.m., indicated Resident 6 refused all medications, blood pressure check, insulin check, insulin administration, and shower this shift.A nursing progress note, dated 5/21/25 at 9:39 p.m., indicated Resident 6 refused all evening medications and nursing care.A nursing progress note, dated 5/24/25 at 10:33 p.m., indicated Resident 6 refused all evening medications.A nursing progress note, dated 5/29/25 at 9:58 a.m., indicated Resident 6 talked about a man wants to marry her and to tell him to stop asking He does not come in her room, he yells it through the walls.A nursing progress note, dated 5/29/25 at 9:43 p.m., indicated Resident 6 refused all evening medications except insulin.A nursing progress note, dated 5/31/25 at 11:27 p.m., indicated Resident 6 refused all evening medications and nursing care. Resident 6 was educated on the risks of refusing prescribed medications. She said she understood but just did not want it.A nursing progress note, dated 6/2/25 at 9:27 p.m., indicated Resident 6 refused medications, glucometer check, and blood pressure reading on this shift.A nursing progress note, dated 6/4/25 at 9:43 p.m., indicated Resident 6 refused evening medications and nursing care. Resident 6 stated Get out!A nursing progress note, dated 6/13/25 at 5:38 p.m., indicated Resident 6 was visibly upset by her room move this shift. Resident 6 verbally yelled out No at staff when attempting to pass medications and get blood sugars for insulin.A nursing progress note, dated 6/15/25 at 12:36 a.m., indicated Resident 6 refused medications and nursing care. A nursing progress note, dated 6/26/25 at 9:39 a.m., indicated Resident 6 requested medication for nausea, the medication was given to the resident, then the resident said she did not receive the medication and wanted to talk to management. Administration checked on Resident 6, and she was resting in bed.A nursing progress note, dated 7/5/25 at 2:04 p.m., indicated Resident 6 stated housekeeping did not clean her room when they did this morning and she did not get her medication, but she did. A nursing progress note, dated 7/7/25 at 9:32 p.m., indicated Resident 6 refused her (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nightly medications and education was provided.A nursing progress note, dated 7/9/25 at 12:28 a.m., indicated Resident 6 refused her blood sugar check. A nursing progress note, dated 7/11/25 at 5:14 p.m., indicated Resident 6 requested to talk to the boss, was leery of staff, and asked to see name badges. It was explained that the boss was out of facility. Resident 6 was pleasant and thankful after dinner was served.A nursing progress note, dated 7/12/25 at 1:35 a.m., indicated Resident 6 refused her blood sugar check and insulin. Resident 6 stated I don't need that. She was pleasant with staff.A nursing progress note, dated 7/12/25 at 9:22 a.m., indicated Resident 6 refused her a.m. blood sugar check, blood pressure check, and medications. A nursing progress note, dated 7/13/25 at 12:10 a.m., indicated Resident 6 refused her blood sugar check and insulin. She yelled at staff wanting a pillow removed from under her head. Resident 6 demanded to see staffs name badge. The pillow was removed from her room and the resident then calmed down.A nursing progress note, dated 7/14/25 at 2:17 p.m., indicated Resident 6 refused her midday medications. She was unhappy with lunch, was offered alternatives, and refused.There were no other documented behaviors in the nursing progress notes between 4/27/25 and 7/14/25.A psychiatric nurse practitioner (NP) progress note, dated 7/15/25 at 4:29 p.m., indicated the visit was for an initial psychotropic medication management and evaluation of mood and behavior. The treatment plan included adding the diagnoses of schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia and mood disorder symptoms), borderline personality disorder (a serious mental health condition characterized by intense, unstable emotions and moods), and delusions (fixed, false beliefs). Seroquel (an antipsychotic medication) 25 milligram (mg) was ordered.Resident 6 had no prior history of schizoaffective disorder, and the clinical record did not contain a comprehensive evaluation to support the new diagnoses added by the nurse practitioner.There were no progress notes, assessments or events documented in the electronic medical record to indicate Resident 72 had displayed behaviors deemed to be dangerous to the resident or others or incidents where the resident was in distress, not redirectable, or warranted the initiation of an antipsychotic medication.During an interview, on 4/9/26 at 12:33 p.m., Resident 6's representative indicated the resident did not have a history of mental health disorders and had never had a mental health hospitalization. The representative indicated she did not know about Resident 6's diagnoses of schizoaffective disorder. The resident had lived by herself before being admitted to the facility and liked to be by herself in her apartment.During an interview, on 4/10/26 at 11:31 a.m., RN 4 indicated Resident 6 would refuse medications and hygiene care at times. She yelled at staff but was not violent. She moved from the second to the third floor in June of 2025 and had a rough transition in the beginning.During an interview, on 4/10/26 at 11:32 a.m., LPN 5 indicated Resident 6 had good and bad days. Sometimes she would take her medications and other times she would refuse. During an interview, on 4/10/26 at 11:32 a.m., the Director of Nursing (DON) indicated the facility followed the federal regulations.A current facility policy, titled PSYCHOTROPIC MEDICATION USE dated 4/29/25 and received from the Executive Director on 4/10/26 at 12:49 p.m., indicated .nonpharmacological interventions are considered and used when indicated, instead of, or in addition to, medication.Psychotropic medications will only be used when medically indicated to treat a specific condition.On-going monitoring of target behaviors will be documented as they occur in the clinical record along with the interventions used to reduce and the results.Behavior Monitoring: Specific target behaviors which cause the resident to represent a danger to self or others or cause the resident distress and impairment in functional abilities. OR symptoms are identified as being due to mania or psychosis (Such as: auditory, visual or other hallucinations; delusions [such as grandiose or paranoia]). Episodes will be documented in the clinical record as they occur along with the results of the interventions used to reduce the behavior or symptom.410 IAC (Indiana Administrative Code) 3.1-3(w)

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure Preadmission Screening and Record Review (PASARR) screenings were accurate and updated when new mental health diagnoses and medications were initiated for 3 of 7 residents reviewed for PASARR. (Resident 5, 6 and 81)Findings include:1. The clinical record for Resident 5 was reviewed on 4/7/26 at 3:14 p.m. The diagnoses included, but were not limited to, dementia, anxiety, depression, and post-traumatic stress disorder (PTSD). A PASARR screen, dated 11/14/25, indicated the resident had diagnoses of anxiety, depression, and dementia and was taking sertraline and quetiapine. It did not include the diagnosis of PTSD or the medication Pristiq. An admission Minimum Data Set (MDS) assessment, dated 11/14/25, indicated the resident had a diagnosis of PTSD. A care plan, dated 11/14/25, indicated Resident 5 had mood issues in relation to the diagnoses of anxiety and PTSD. A physician's order, dated 12/16/25, indicated to administer Pristiq (an antidepressant medication) 50 mg (milligrams) one time a day for depression. During an interview, on 4/8/26 at 2:48 p.m., the Assistant Director of Nursing (ADON) indicated the resident did have a diagnosis of PTSD on admission. She would submit a new level 1 to include all Resident 5's diagnoses and psychoactive medications. 2. The clinical record for Resident 6 was reviewed on 4/9/26 at 10:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, borderline personality disorder, delusional disorder, schizoaffective disorder, and depression. A PASARR screen, dated 3/7/25, indicated the resident had diagnoses of depression and dementia and was taking sertraline on admission. New diagnoses of borderline personality disorder, delusional disorder, and schizoaffective disorder were added to Resident 6's diagnoses list on 7/15/25. A physician's order, dated 11/4/25, indicated to administer quetiapine (an antipsychotic medication) 100 mg (milligrams) one time a day for borderline personality disorder. A quarterly MDS assessment, dated 12/12/25, indicated Resident 6 had diagnoses of psychotic disorder, schizophrenia, and depression and was taking antipsychotic and antidepressant medications. During an interview, on 4/10/26 at 11:15 a.m., the ADON indicated a new level I should have been completed when new mental health diagnoses and medications were added. 3. The clinical record for Resident 81 was reviewed on 4/7/26 at 3:09 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety disorder, irritability and anger, and (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nonrheumatic aortic valve stenosis. A PASARR screen, dated 1/5/26, indicated Resident 81 had diagnoses of dementia and anxiety and was taking Risperdal. It did not include the diagnosis of depression or the medications escitalopram or lorazepam. A physician's order, dated 1/6/26, indicated to administer escitalopram oxalate (an antidepressant medication) 5 mg (milligrams) one time a day for depression. A physician's order, dated 1/6/26 and discontinued 1/20/26, indicated to administer lorazepam 0.5 mg (an antianxiety medication) two times a day for anxiety. An admission MDS assessment, dated 1/12/26, indicated the resident had a diagnosis of depression and was taking antianxiety and antidepressant medications. The resident was not currently considered by the state level II PASARR process to have a serious mental illness. During an interview, on 4/8/26 at 2:25 p.m., the ADON indicated the PASARR screen was completed prior to the resident's arrival and should have included all mental health diagnoses and medications. A new level I screen needed to be submitted to include all Resident 81's diagnoses and psychoactive medications. A current facility policy, titled Pre-admission Process/Admissions, dated 12/11/18 and provided by the Executive Director (ED) on 4/9/26 at 9:10 a.m., indicated .A nursing facility must notify the state mental health authority .promptly (within 14 days) after a significant change in the mental .condition of a resident .for resident review .A Level 1 screen is required .For residents .who have experienced a significant change in mental status that suggest the need .a subsequent Level I review .Examples of a mental status change event include: A new mental health diagnosis that is not listed on previous/initial L1 or Level II. A newly prescribed psychotropic medication for mental illness. 410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1) 410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(2)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure a resident had qualifying criteria to warrant a new schizoaffective disorder diagnosis for 1 of 5 residents reviewed for unnecessary medications. (Resident 6)Findings include:The clinical record for Resident 6 was reviewed on 4/9/26 at 10:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, borderline personality disorder, delusional disorder, schizoaffective disorder, and depression. A preadmission screening and resident review (PASSAR), dated 3/7/25, indicated Resident 6 had diagnoses of depression and dementia and was taking sertraline (a medication used to treat depression). An admission minimum data set (MDS) assessment, dated 3/17/25, indicated Resident 6 had a severe cognitive impairment, the diagnoses of Alzheimer's disease and depression, and was treated with an antidepressant medication.A nursing progress note, dated 4/27/25 at 1:21 p.m., indicated Resident 6 had indicated there were two men causing trouble and bothering her and her neighbor (the room next door). Resident 6 stated these two men were Siamese and made high pitch whistle sounds.A nursing progress note, dated 5/8/25 at 7:08 p.m., indicated Resident 6 thought there was a man in her room today.A nursing progress note, dated 5/14/25 at 9:20 p.m., indicated Resident 6 refused all her evening medications.A nursing progress note, dated 5/16/25 at 9:13 p.m., indicated Resident 6 refused all medications, blood pressure check, insulin check, insulin administration, and shower this shift.A nursing progress note, dated 5/21/25 at 9:39 p.m., indicated Resident 6 refused all evening medications and nursing care.A nursing progress note, dated 5/24/25 at 10:33 p.m., indicated Resident 6 refused all evening medications.A nursing progress note, dated 5/29/25 at 9:58 a.m., indicated Resident 6 talked about a man wants to marry her and to tell him to stop asking He does not come in her room, he yells it through the walls.A nursing progress note, dated 5/29/25 at 9:43 p.m., indicated Resident 6 refused all evening medications except insulin.A nursing progress note, dated 5/31/25 at 11:27 p.m., indicated Resident 6 refused all evening medications and nursing care. Resident 6 was educated on the risks of refusing prescribed medications. She said she understood but just did not want it.A nursing progress note, dated 6/2/25 at 9:27 p.m., indicated Resident 6 refused medications, glucometer check, and blood pressure reading on this shift.A nursing progress note, dated 6/4/25 at 9:43 p.m., indicated Resident 6 refused evening medications and nursing care. Resident 6 stated Get out!A nursing progress note, dated 6/13/25 at 5:38 p.m., indicated Resident 6 was visibly upset by her room move this shift. Resident 6 verbally yelled out No at staff when attempting to pass medications and get blood sugars for insulin.A nursing progress note, dated 6/15/25 at 12:36 a.m., indicated Resident 6 refused medications and nursing care. A nursing progress note, dated 6/26/25 at 9:39 a.m., indicated Resident 6 requested medication for nausea, the medication was given to the resident, then the resident said she did not receive the medication and wanted to talk to management. Administration checked on Resident 6, and she was resting in bed.A nursing progress note, dated 7/5/25 at 2:04 p.m., indicated Resident 6 stated housekeeping did not clean her room when they did this morning and she did not get her medication, but she did. A nursing progress note, dated 7/7/25 at 9:32 p.m., indicated Resident 6 refused her nightly medications and education was provided.A nursing progress note, dated 7/9/25 at 12:28 a.m., indicated Resident 6 refused her blood sugar check. A nursing progress note, dated 7/11/25 at 5:14 p.m., indicated Resident 6 requested to talk to the boss, was leery of staff, and asked to see name badges. It was explained that the boss was out of facility. Resident 6 was pleasant and thankful after dinner was served.A nursing progress note, dated 7/12/25 at 1:35 a.m., indicated Resident 6 refused her blood sugar check and insulin. Resident 6 stated I don't need that. She was pleasant with staff.A nursing progress note, dated 7/12/25 at 9:22 a.m., indicated Resident 6 refused her a.m. blood sugar check, blood pressure check, and medications. A nursing progress note, dated 7/13/25 at 12:10 a.m., indicated Resident 6 refused her blood sugar check and insulin. She yelled at staff wanting a pillow removed from under her head. Resident 6 demanded to see staffs name badge. The pillow was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed from her room and the resident then calmed down.A nursing progress note, dated 7/14/25 at 2:17 p.m., indicated Resident 6 refused her midday medications. She was unhappy with lunch, was offered alternatives, and refused.There were no other documented behaviors in the nursing progress notes between 4/27/25 and 7/14/25.A psychiatric nurse practitioner (NP) progress note, dated 7/15/25 at 4:29 p.m., indicated the visit was for an initial psychotropic medication management and evaluation of mood and behavior. The treatment plan included adding the diagnoses of schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia and mood disorder symptoms), borderline personality disorder (a serious mental health condition characterized by intense, unstable emotions and moods), and delusions (fixed, false beliefs). Seroquel (an antipsychotic medication) 25 milligram (mg) was ordered.Resident 6 had no prior history of schizoaffective disorder, and the clinical record did not contain a comprehensive evaluation to support the new diagnoses added by the nurse practitioner.An assessment to show Resident 6 had a major mood episode which had lasted for an uninterrupted period of time was not located in the clinical record.There was no documentation to indicate a discussion about Resident 6's mental health history or if the delusions were a progression of her diagnosis of Alzheimer's disease was held with the resident's representative. During an interview, on 4/9/26 at 12:33 p.m., Resident 6's representative indicated the resident did not have a history of mental health disorders and had never had a mental health hospitalization. The representative indicated she did not know about Resident 6's diagnoses of schizoaffective disorder. The resident had lived by herself before being admitted to the facility and liked to be by herself in her apartment.During an interview, on 4/10/26 at 11:31 a.m., RN 4 indicated Resident 6 would refuse medications and hygiene care at times. She yelled at staff but was not violent. She moved from the second to the third floor in June of 2025 and had a rough transition in the beginning.During an interview, on 4/10/26 at 11:32 a.m., LPN 5 indicated Resident 6 had good and bad days. Sometimes she would take her medications and other times she would refuse. During an interview, on 4/10/26 at 11:32 a.m., the Director of Nursing (DON) indicated the facility did not have a policy for schizoaffective disorder and the facility followed the federal regulations.410 IAC (Indiana Administrative Code) 3.1-35(g)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a glucometer (a handheld device used to measure blood glucose levels) was sanitized for 1 of 1 resident randomly reviewed for infection control. (Resident 18)Findings include:During an observation, on [DATE] at 11:45 a.m., Registered Nurse (RN) 3 removed a glucometer from the third-floor medication cart. RN 3 placed the glucometer on top of the cart without a clean barrier between the glucometer and the cart. Without cleaning the glucometer, RN 3 took the glucometer, an alcohol pad, and a lancet (a needle used to prick the skin to obtain a tiny blood sample) into Resident 18's room. RN 3 took the resident's blood sugar and placed the glucometer back in the medication cart. RN 3 did not clean the glucometer before or after it was used on Resident 18.The clinical record for Resident 18 was reviewed on [DATE] at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia.A physician's order, dated [DATE], indicated to check the blood glucose reading twice a day.During an interview, on [DATE] at 11:25 a.m., RN 3 indicated she should use a disinfectant wipe to clean the glucometer, and the facility policy instructed staff to use the wipes before and after blood sugars were taken. This would make sure it would be clean for the next resident. When the glucometer was not cleaned, it could cause an infection control problem. During an interview, on [DATE] at 2:19 p.m., Licensed Practical Nurse (LPN) 2 indicated the facility policy was to clean the glucometers before and after each resident. The glucometers were to be cleaned with the wipes stored in the medication cart. This would reduce the risk of a resident developing an infection.During an interview, on [DATE] at 2:45 p.m., the Clinical Support Nurse indicated the facility had the disinfectant wipes to clean the glucometer. The wipes were stored in each medication cart. The policy was to clean the glucometer before and after each resident. A current facility policy, titled Cleaning Of Glucometer, dated as revised on [DATE] and provided by the Administrator on [DATE] at 12:06 a.m., indicated .To maintain infection control between resident use.The Glucometer will be disinfected after completing a blood sugar using a commercial disinfectant wipe.and completely wiping down the glucometer so it is visibly wet.Follow manufacturer's instructions related to length of time to disinfect before reusing. Air dry time is typically around 30 seconds, so you must rewet the meter or wrap the wet wipe around the meter after wiping it down.Place wrapped Glucometer in covered container and set timer for manufacturer's contact kill time.Once contact kill time has expired, wait and allow to air dry before re-using the glucometer.410 IAC (Indiana Administrative Code) 3.1-18(b)(1)