

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Miller's Health & Rehab by Miller's Merry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 Monroe Street LA Porte, IN 46350	

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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a stat (immediate) chest X-ray was reported timely, eye drops were administered as ordered by the physician, a skin tear was treated and monitored, and a resident was treated for constipation for 1 of 1 resident reviewed for hospitalization and 1 of 1 resident reviewed for constipation. (Residents B and G) Findings include: 1. The closed record for Resident B was reviewed on 7/22/25 at 1:30 p.m. Diagnoses included but were not limited to, anemia, kidney failure, heart failure, high blood pressure, falls, glaucoma, and heart disease. The admission Minimum Data Set (MDS) assessment, dated 3/14/25, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 3/10/25, indicated the resident had visual impairment related to glaucoma. The approaches were to instill medication as per physician orders. A Care Plan, dated 3/17/25, indicated the resident had a skin tear to the right great toe. A Care Plan, dated 3/18/25, indicated the resident tested positive for COVID-19. A Physician's Order, dated 3/7/25 and discontinued on 3/11/25, indicated Travoprost (an eye drop used for glaucoma) Solution 0.004 %, instill one drop in both eyes in the evening for glaucoma. A Physician's Order, dated 3/11/25 and discontinued 3/14/25, indicated Travoprost (an eye drop used for glaucoma) Solution 0.004 %, instill one drop in both eyes at bedtime for glaucoma. A Physician's Order, dated 3/14/25, indicated Travoprost (an eye drop used for glaucoma) Solution 0.004 %, instill one drop in both eyes at bedtime for glaucoma patient supplied. The Medication Administration Record (MAR) for the month of 3/2025, indicated the eye drops were not signed out as being administered and coded with a 3 (indicating the medication was not available) on 3/8, 3/9, 3/10, 3/11, and 3/12/25. Documentation in the nurses' notes, dated 3/8, 3/9, 3/10, 3/11, and 3/12/25, indicated Travoprost Solution 0.004 %, instill one drop in both eyes in the evening for glaucoma. The medication was unavailable at this time. Nurses' Notes, dated 3/12/25 at 7:46 p.m., indicated the resident's daughter brought the Travoprost eye drops due to them not being available from pharmacy. A Nursing Initial Occurrence, dated 3/14/25 at 10:10 p.m., indicated the resident's right great toe got stuck under the wheel of the wheelchair. A skin tear was sustained measuring 0.75 centimeters (cm) in length by 0.5 cm.in width. The CNAs were instructed to make sure the resident was wearing shoes or non-slip socks during transfers and transports. The skin tear was cleansed with soap and water and covered with ABD and tape. The next and last Nursing Occurrence Follow Up Assessments were completed on 3/15/25 at 3:28 p.m. and 10:56 p.m. The directions on the form indicated Complete follow-up assessments for all occurrences each shift for 24 hours, if an injury occurred complete each shift for 72 hours. A Physician's Order, dated 3/17/25, indicated cleanse the skin tear to the right great toe with normal saline and apply Comfitel (a silicone wound dressing) contact layer and cover with a bordered foam. Change twice weekly on Tuesday and Friday and as needed for soilage or dislodgement. There were no treatment orders for the skin tear until 3/17/25. The Treatment Administration Record (TAR) for the month of 3/2025 indicated the treatment for the skin tear was not signed out as being completed on Tuesday 3/18/25. A Nurses' Note, dated 3/15/25 at 2:37 p.m., indicated staff messaged the doctor to obtain an order for Zofran as needed for nausea and dry heaving. There was no other documentation earlier in the day to indicate the resident was nauseated or vomiting. A Physician's Order, dated 3/15/25 at 2:52 p.m., indicate Zofran (a medication used for nausea) give 4 mg by mouth every four hours as needed for nausea and vomiting. Nurse Practitioner (NP) Note, dated 3/21/25 at 11:43 a.m., indicated the patient had a cough with congestion and a chest X-ray would be ordered. A Physician's Order, dated 3/21/25 at 11:43 a.m., indicated stat chest X-ray for shortness of breath. A Nurses' Note, dated 3/21/25 at 6:26 p.m., indicated the daughter called and asked if the resident could get Tessalon Pearls (a medication used for cough). The physician ordered the Tessalon pearls 200 mg three times a day as needed. A Physician's Order, dated 3/21/25 at 9:04 p.m., indicated Benzonatate Capsule 200 mg, give one tablet every eight hours as needed for cough. The order was not put in the computer until 9:04 p.m. so it could be sent to the pharmacy. A Nurses Note, dated 3/22/25 at 8:41 a.m., indicated the chest X-ray results were received and daughter and physician were notified. There was no documentation in the clinical record regarding nursing staff following up on the results of the stat chest X-ray on 3/21/25. During an interview on 7/24/25 at 3:45 p.m., the Assistant Director of Nursing (ADON) indicated the eye drops were not available from the pharmacy. During an interview on 7/25/25 at 11:36 am., the ADON indicated there was no follow up vital signs after the skin tear on the right great toe and there was no treatment order for the skin tear until 3/17/25. The treatment was not signed out on 3/18/25. The Tessalon</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, record review, and interview, the facility failed to ensure indwelling Foley (urinary) catheter tubing was kept off the floor, urinary outputs were documented, and urinalysis was collected in a timely manner for 2 of 3 residents reviewed for catheters. (Residents H and E) Findings include: 1. During random observations on 7/21/25 at 10:16 a.m. and 12:40 p.m., Resident H was observed sitting in a wheelchair. At those times, an indwelling Foley catheter was observed underneath the wheelchair and the bottom of the bag was on the floor.</p> <p>The record for Resident H was reviewed on 7/23/25 at 10:07 a.m. Diagnoses included, but were not limited to, right femur fracture, obstructive and reflux uropathy (a condition where urine flows backward from the bladder into the ureters and potentially the kidneys), urine retention and chronic kidney disease.</p> <p>The 6/26/25 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling Foley catheter.</p> <p>The Care Plan, dated 6/13/25, indicated the resident required the use of a catheter due to untreatable urinary retention. The approaches were to document urinary output.</p> <p>A Physician's Order, dated 6/16/25, indicated Foley catheter #16 with a 10 milliliter balloon.</p> <p>A Physician's Order, dated 7/4/25, indicated the Foley catheter was to be switched to leg bag during the day and privacy bag at bedtime.</p> <p>A Physician's Order, dated 7/6/25, indicated Keflex (an antibiotic) 500 milligrams (mg) three times a day for seven days for an urinary tract infection.</p> <p>The urinary output documentation in the CNA task section indicated the output was incomplete on the day shift on 6/14, 6/15, 6/21, 6/27, 7/8, and 7/11/25, on the evening shift on 7/2 and 7/17/25 and on the midnight shift on 6/25/25.</p> <p>During an interview on 7/24/25 at 1:45 p.m., the Nurse Consultant indicated the Foley catheter bag should not have been touching the floor.</p> <p>During an interview on 7/24/25 at 3:45 p.m., the Administrator had no additional information to provide regarding the urinary output not being completed.</p> <p>The current 6/15/2010 Output Monitoring policy, provided by the Assistant Director of Nursing (ADON) on 7/25/25 at 11:40 a.m., indicated output will be monitored each shift and documented in the medical record in point click care.</p> <p>The current 8/30/2007 Foley Catheter and Maintenance policy, provided by the ADON on 7/25/25 at 11:40 a.m., indicated ensure the bag or tubing was not touching the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a random observation on 7/21/2025 at 1:02 p.m., Resident E was moaning, indicating her back hurt when she tried to move. At that time, LPN 2 indicated she informed the doctor of the pain. He told her to give the resident Tylenol and that he would come see the resident.</p> <p>The record for Resident E was reviewed on 7/23/25 at 10:45 a.m. Diagnoses included, but were not limited to, diabetes, heart failure, and acute kidney failure.</p> <p>The 5/29/25 5-Day Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, required moderate assistance with activities of daily living (ADLs) and maximal assistance with transfers.</p> <p>A Physician's Note, dated 7/21/25 at 6:34 p.m., indicated the resident had complaint of pelvic and back pain, and staff was to obtain a urine sample for urinalysis and culture with antibiotic sensitivity.</p> <p>A Physician's Order, dated 7/22/25, indicated to straight cath (insert temporary catheter to drain the bladder) the resident to obtain the urine sample.</p> <p>A Progress Note, dated 7/23/25, indicated a Foley catheter (tube inserted and maintained in the bladder to drain urine) was to be inserted due to an unsuccessful attempt to straight cath.</p> <p>During an interview on 7/24/25 at 1:45 p.m., the Nurse Consultant indicated the process for obtaining a urine sample for analysis should be more timely.</p> <p>This citation relates to Complaint 1554511.</p> <p>3.1-41(a)(2)</p>