STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had physician's orders for the medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 23 and F)1. During random observations on 7/21/25 at 11:00 a.m. and 3:24 p.m., on 7/22/25 at 10:18 a.m. and 3:33 p.m., on 7/23/25 at 9:37 a.m. and 2:38 p.m., and on 7/24/25 at 11:13 a.m., Resident 23 was observed sitting in a recliner chair. At those times, there was a tube of Neosporin cream on the over bed table. During an interview on 7/21/25 at 11:00 a.m., the resident indicated he used the cream for his dry skin on his arms. On 7/24/25 at 11:26 a.m., RN 1 entered the resident's room and observed the Neosporin cream on the over bed table. During an interview on 7/24/25 at 11:30 a.m., RN 1 indicated the resident told her his family brought it in and he used it on his arms for the scabs. She removed the cream and will see about getting an order for it and complete an assessment for the resident to apply the cream himself. The record for Resident 23 was reviewed on 7/22/25 at 3:16 p.m. Diagnoses included, but were not limited to, fracture of the left femur, anxiety disorder, major depressive disorder, heart disease, and high blood pressure. The admission Minimum Data Set (MDS) assessment, dated 6/8/25, indicated the resident was moderately impaired for daily decision making. There was no care plan for the resident to self-administer his own medications. There was no self-administration of medication assessment for the resident to use the Neosporin cream. There was no physician's order for the Neosporin cream. During an interview on 7/24/25 at 1:45 p.m., the Administrator had no additional information to provide. The current 3/1/2001 Self Administration of Meds Procedure and Assessment policy, provided by the Assistant Director of Nursing on 7/25/25 at 11:40 a.m., indicated an assessment of the resident's abilities to self-administer meds will be completed prior to initiation of training. Upon completion of the assessment, the nurse assessor must sign and date the form and forward to the Director of Nursing for follow up. A final decision will be made by the team, along with the family, resident, and Physician whether or not the resident will be given the right to self-administer the medications. 2. During random observations on 7/23/25 at 3:50 p.m. and on 7/24/25 at 11:14 a.m., Resident F was observed in her room. At those times, there was a facility labeled box of Fluticasone Nasal spray on the night stand. On 7/24/25 at 11:26 a.m., LPN 1 entered the room and observed the Fluticasone Nasal spray on the night stand. During an interview at that time, LPN 1 indicated the resident had no order for Fluticasone, nor could she self-administer the medication. The record for Resident F was reviewed on 7/23/25 at 10:50 a.m. Diagnoses included, but were not limited to, osteomyelitis of the sacral region, COPD (Chronic obstructive pulmonary disease), acute respiratory failure, pressure ulcer of the sacral region, emphysema, major depressive disorder, and anxiety disorder. The admission Minimum Data Set (MDS) assessment, dated 6/10/25, indicated the resident was moderately intact for daily decision making. There was no care plan for the resident to self-administer his own medications. There was no self-administration of medication assessment for the resident to use Fluticasone Nasal spray. There was no physician's order for the Fluticasone Nasal spray. During an interview on 7/24/25 at 1:45 p.m., the Administrator had no additional information to provide. The current 3/1/2001 Self Administration of Meds Procedure and Assessment policy, provided by the Assistant Director of Nursing on 7/25/25 at 11:40 a.m., indicated an (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
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment of the resident's abilities to self-administer meds will be completed prior to initiation of training. Upon completion of the assessment, the nurse assessor must sign and date the form and forward to the Director of Nursing for follow up. A final decision will be made by the team, along with the family, resident, and Physician whether or not the resident will be given the right to self-administer the medications. 3.1-11(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interview, the facility failed to ensure personal privacy was maintained related to the computer screen being left open with resident information visible on 1 of 2 units throughout the facility. (The 100 unit)Finding includes:During a random observation on 7/21/25 at 10:22 a.m., the computer screen on the front 100 unit medication cart was left open and resident information was visible. At 10:33 a.m., the computer screen was still open. RN 1 returned to the cart and walked away from the cart at 10:35 a.m. The RN did not close the computer prior to walking away. At 10:41 a.m., the RN returned to the medication cart. At 10:44 a.m., she walked away from the medication cart to answer a phone call, again, she did not close the computer prior to walking away. The RN returned to the medication cart at 10:46 a.m. At 10:50 a.m., the RN walked away from the medication cart with resident information visible. Staff and other residents were observed in the hallway at that time. During an interview on 7/23/25 at 4:45 p.m., the Nurse Consultant indicated the nurse should have closed the computer screen each time she walked away. The current facility policy titled, Medication Administration Procedure was provided by the Nurse Consultant on 7/23/25 at 4:55 p.m. The policy indicated the computer screen was to be locked prior to walking away. 3.1-3(o)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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. **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 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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	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 pearls were delivered to the facility on 3/22/25 at 6:25 p.m. There was no documentation or assessment of the resident having any nausea or vomiting on 3/15/25 prior to getting the order for the Zofran. The X-ray company was called by nursing staff at 1:02 p.m. (79 minutes after the order was written). The company arrived to the facility and obtained the chest X-ray at 2:55 p.m. and results were signed by the Physician on 3/22/25 at 1:07 a.m. She indicated a stat X-ray was to be obtained and completed within four hours. She would have expected nursing staff to follow up with the X-ray company as to what the results were. 2. During an interview on 7/22/25 at 10:50 a.m., the resident indicated she has not had a bowel movement in a while. The record for Resident G was reviewed on 7/23/25 at 9:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, fracture of left humerus, fracture of left wrist, hypothyroidism, and laceration of the eyelid. The admission Minimum Data Set (MDS) assessment was still in progress. A Care Plan, dated 7/20/25, indicated the resident had the potential for constipation. The approaches were to administer laxatives and/or stool softeners as ordered. A Nurses' Note, dated 7/21/25, indicated the resident had complaints of having no bowel movement in a few days. The physician was notified and new orders were obtained. There were no other nursing progress notes regarding the resident's complaints of constipation. A Physician's Order, dated 7/20/25, indicated Hydrocodone (a narcotic) 7.5-325 mg, give one tablet every six hours as needed for pain. Physician's Orders, dated 7/21/25, indicated Milk of Magnesia 400 milligrams (mg), give 30 milliliters (ml) every 24 hours as needed for constipation. Miralax oral powder 17 grams, give one scoop one time a day for constipation and Sennosides 8.6 mg, give two tablets one time for constipation. A Physician's Order, dated 7/22/25, indicated Hydrocodone (a narcotic) 7.5-325 mg, give one tablet two times a day for pain. The 7/2025 Medication Administration Record (MAR) indicated the resident received 5 doses of the as needed Hydrocodone from 7/21-7/22/25. The resident did not receive the as needed Milk of Magnesia. She received one dose of the Sennosides on 7/21/25, no dose on 7/22/25 and one dose on 7/23/25. The three-day bowel pattern record indicated no bowel movement was documented from 7/20/25 at 3:42 p.m. through 7/23/25 2:22 p.m. The bowel movement documentation every shift indicated a small bowel movement was recorded on 7/21/25 at 2:10 p.m. During an interview on 7/24/25 at 3:45 p.m., the Assistant Director of Nursing (ADON) indicated it was documented the resident had a bowel movement on 7/21/25 at 2:10 p.m. She was not aware the three-day bowel movement pattern indicated the resident had no bowel movement on 7/21/25. She was aware the resident did not receive the as needed Milk of Magnesia. There was no follow up documentation regarding the resident's complaints of constipation. The current 3/1/2001 Bowel Elimination policy, provided by the ADON on 7/25/25 at 11:40 a.m., indicated if a resident complained of constipation, or at least on the third day with no bowel movement, an ordered bowel aid or stool softener will be administered. This citation relates to Complaint 1554512. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure wound vac (vacuum) tubing was kept off the floor and treatments were followed as ordered by the physician for 2 of 4 residents reviewed for pressure ulcers. (Residents F and 44)Findings include:1. During random observations on 7/21/25 at 10:36 a.m., on 7/22/25 at 3:40 p.m., on 7/23/25 at 9:38 a.m., 11:40 a.m., 12:10 p.m., and 2:39 p.m., and on 7/24/25 at 11:14 a.m., Resident F was observed in bed. At those times a wound vac (a specialized dressing and a vacuum pump that creates gentle suction on a wound to help it heal faster) was contained in a bag and observed on the floor next to the bed. The wound vac tubing was not contained and was laying directly on the floor. On 7/24/25 at 11:26 a.m., LPN 1 entered the room and observed the wound vac tubing on the floor.During an interview at that time, LPN 1 indicated the tubing should be contained inside the bag and off the floor.During a wound treatment observation 7/25/25 at 10:30 a.m. the resident was observed with a large wound to the sacrum. The wound was pink with a scant amount of drainage noted. The record for Resident F was reviewed on 7/23/25 at 10:50 a.m. Diagnoses included, but were not limited to, osteomyelitis of the sacral region, COPD (Chronic obstructive pulmonary disease), acute respiratory failure, pressure ulcer of the sacral region, emphysema, major depressive disorder, and anxiety disorder.The admission Minimum Data Set (MDS) assessment, dated 6/10/25, indicated the resident was moderately intact for daily decision making and was admitted to the facility with one Stage 4 pressure ulcer (the most severe stage of a pressure injury, characterized by full-thickness skin and tissue loss with potential exposure of bone, tendon, or muscle).The Care Plan, dated 5/30/25, indicated the resident had a pressure ulcer to the coccyx region. A Physician's Order, dated 5/30/25 and discontinued on 6/20/25, indicated Meropenem (an antibiotic) Intravenous Solution Reconstituted 1 gram every eight hours for osteomyelitis of the wound. A Physician's Order, dated 7/1/25 indicated wound vac to coccyx, monitor for suction and functioning every shift. The wound was measured last on 7/23/25. The Stage 4 sacral wound measured 3.3 centimeters (cm) in length by 3.1 cm in width by .03 cm deep. The wound was moist and pink with new undermining noted from 6 o'clock to 10 o'clock 0.5 cm depth. During an interview on 7/24/25 at 1:45 p.m., the Nurse Consultant indicated the wound vac tubing should not have been on the floor. 2. The record for Resident 44 was reviewed on 7/23/25 at 11:58 a.m Diagnoses included, but were not limited to, dementia, diabetes, and pressure ulcer.The 5/30/25 admission Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required moderate assistance with activities of daily living (ADLs) and transfers. A Wound Care Plan, dated 5/23/25, indicated to administer treatments as ordered.A 6/4/25 Physician's Order indicated the following wound care: cleanse coccyx (tailbone area) wound with wound cleanser, pat dry, apply Dakin's (an antiseptic) soaked gauze (wet to moist) to wound bed, and cover with a bordered foam dressing; change daily and as needed for soilage or dislodgement. The July 2025 treatment record indicated this treatment was provided daily from 7/1/25 through 7/23/25. A 7/9/25 wound clinic note indicated the following coccyx wound care orders: cleanse with Dakin's, tuck Exufiber (a gelling fiber wound dressing) into the wound, apply 4X4 gauze, and cover with bordered foam dressing daily. Assessments of the coccyx wound indicated: 7/3/25 left upper coccyx, stage 4, 8.2 cm long, 6 cm wide, 1.7 cm deep, light serous (yellow/clear drainage), no tunnelling; 7/10/25 left upper coccyx, stage 4, 5.3 cm long, 4.4 cm wide ,1.5 cm deep, light serous drainage, no tunnelling; 7/17/25 left upper coccyx, stage 4, 4.6 cm long, 4 cm wide, 1.3 cm deep, light serous drainage, no tunnelling; During an interview on 7/24/2025 at 9:48 a.m., the Wound Nurse indicated she was not aware of the new treatment orders. The wound clinic would normally notify her of new orders, but she thought they must not have changed the treatment because the wound was healing. 3.1-40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 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. 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. 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. 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. A Physician's Order, dated 6/16/25, indicated Foley catheter #16 with a 10 milliliter balloon. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. This citation relates to Complaint 1554511. 3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Health & Rehab by Miller's Merry Manor	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to ensure food consumption logs and health supplements were completed for a resident with a history of weight loss for 1 of 1 resident reviewed for nutrition. (Resident 3)Finding includes:The record for Resident F was reviewed on 7/23/25 at 10:50 a.m. Diagnoses included, but were not limited to, osteomyelitis of the sacral region, COPD (Chronic obstructive pulmonary disease), acute respiratory failure, pressure ulcer of the sacral region, emphysema, major depressive disorder, and anxiety disorder. The admission Minimum Data Set (MDS) assessment, dated 6/10/25, indicated the resident was moderately intact for daily decision making and needed supervision and set up assistance with eating. She weighed 93 pounds and received a regular diet. The Care Plan, dated 6/20/25, indicated the resident was at nutritional risk related to a pressure ulcer. The approaches were to serve a four-ounce house supplement at breakfast, lunch, and dinner and to monitor meal intakes. The resident weighed 93 pounds on 5/31/25. The resident weighed 89 pounds on 6/10/25 and 100 pounds on 7/14/25. Her weight on 7/21/25 was 94 pounds. A Registered Dietitian's (RD) Progress Note, dated 6/24/25, indicated the resident's Body Mass Index was 16 (indicating the resident was significantly underweight) and was to receive a house supplement for all three meals. The food consumption meal intakes were not documented for breakfast on 6/9, 7/7, 7/17, 7/18, 7/19, and 7/20/25. They were not documented for lunch on 6/9, 7/7, 7/17, 7/18, 7/19, and 7/20/25 and dinner on 7/1 and 7/2/25. The house supplement intakes found in the CNA task section were not documented for breakfast on 7/1, 7/7 7/17, 7/18, 7/19, and 7/20/25. They were not documented for lunch on 7/1, 7/7, 7/17, 7/18, 7/19, and 7/20/25 and for dinner on 7/2/25. During an interview on 7/24/25 at 1:45 p.m., the Administrator had no additional information to provide. The current 9/23/14 Point of Care Documentation policy, provided by the Assistant Director of Nursing on 7/25/25 at 11:40 a.m., indicated documentation was required each shift for all tasks that were assigned to the resident. Routine tasks assigned to residents were documentation of meal intakes. 3.1-46(a)(2)