STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155299	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	5909 Lute Rd Portage, IN 46368

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure a resident received proper assistance to prevent accidents, related to a CNA (CNA 1) transferring a dependent resident from a chair to the bed without following the plan of care, causing an injury to the left lower leg, which required an emergency room (ER) visit and 19 sutures to the injury, for 1 of 3 residents reviewed for mechanical lift usage. (Resident E)Finding includes: During an observation on 10/14/25 at 10:53 a.m., CNA 2 and CNA 3 used a mechanical lift and transferred Resident E from the bed to a chair. There was a light pink area observed on the resident's left lower calf area. CNA 2 indicated the resident had been previously transferred from a chair to the bed without the use of the mechanical lift and an injury occurred to the left lower leg. Resident E's record was reviewed on 10/14/25 at 3:22 p.m. The diagnosis included, but were not limited to, rheumatoid arthritis and osteoporosis.A Care Plan, dated 12/17/24, indicated the resident was dependent on staff for activities of daily living (ADL's). The interventions indicated the staff were to refer to the Nurse Aide Assignment sheet (Pocket Guide) for details on transfer assistance. An intervention added on 4/4/25 indicated a mechanical lift was to be used for transfers.A Physician's Order, dated 4/3/25, indicated a mechanical lift for transfers could be utilized.A Nurse Aide Pocket Guide, dated 7/18/25, indicated the resident was to be transferred with a mechanical lift.A Nursing-Occurrence Assessment, dated 7/30/25 at 6:45 p.m., indicated the resident was in her room. A skin tear to the left lower leg occurred after the resident had been transferred from the wheelchair to the bed. The resident was lying on her back, leaning to the left side. Her legs were extended out of the bed. A staff member was applying pressure to the left lower leg area and there was a pool of blood on the floor. There was a 14 centimeter (cm) by 5.5 cm skin tear on the left lower leg with continuous bleeding. The Physician was notified and an order was received for the resident to be transferred to the ER (emergency room) if the bleeding continued. The resident had been transferred to the hospital ER.A Post Occurrence IDT (Interdisciplinary Team) and Fall Risk Assessment, dated 7/30/25 at 6:45 p.m., indicated the CNA had transferred the resident from the wheelchair to the bed. There was a partial flap loss skin tear to the left lower leg that measured 14 cm by 5.5 cm. The leg had been bumped on the wheelchair during the transfer. The staff member was educated due to the improper transfer technique. A sheepskin was applied to the wheelchair for protection. The resident was to be transferred with the mechanical lift.The ER documentation, dated 7/30/25 at 9:29 p.m., indicated the sutures were to be removed in eight to ten days.There was no documentation that indicated what time the resident returned to the facility or an assessment of the injury of the left lower extremity.A Concern/Grievance, dated 7/31/25 at 8:45 a.m., indicated a skin tear was obtained from an improper transfer technique. The injury required an ER visit and sutures. The investigation indicated CNA 2 stated she always used a mechanical lift when the resident needed to be transferred. The lift had been used when the resident was transferred from the bed to the chair and the pad for the mechanical lift had been removed from under the resident at her request. CNA 2 had reported to CNA 1 at the change of shift that the pad would have to be placed back under the resident when she was transferred from the chair to the bed. CNA 1 had indicated she was aware the resident required a mechanical lift to be used when transferred. The pad had not been underneath the resident, so she had transferred the resident by herself into the bed.A Wound-Non-Pressure Wound Assessment (the first assessment documented upon return from ER), dated 8/5/25 at 11:13 a.m., indicated the left lower extremity wound was 13.5 cm length by 8.5 cm width with a depth of 0.1 cm. The injury was irregular shaped and open with unattached and irregular wound edges. The area had redness, was moist, and the peeled skin had 19 sutures. There was moderate sanguineous drainage from the area and the resident indicated it hurt a little bit. A Quarterly Minimum Data Set assessment, dated 9/10/25, indicated a severely impaired cognitive status, no behaviors, and was dependent on staff for all transfers.During an interview on 10/14/25 at 1:22 p.m., CNA 1 indicated she was under the impression the resident could be transferred without the mechanical lift on 7/30/25. The resident was sitting in the chair and had wanted to go to bed. She had transferred her to the bed and then saw the blood and called for help. She indicated there was not a mechanical lift pad underneath the resident and she was unsure how to put the pad underneath her while she was in the chair. The resident's skin was snagged by a piece on the wheelchair. The facility has pocket guides the CNA's carry that informed them of what type of care the residents required. That night, there were none available and she had been told they were updating them. She had taken care of the resident prior and had not known she required a mechanical lift for transfers. She had been told by other staff she could lift the resident into