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	03/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to ensure each residents' dignity and rights were maintained related to not responding to complaints of excessive television volume in a timely manner for 3 of 4 resident council members and one random resident that resided on the 100 unit. (Residents 6, 30, 41 and 45)Finding includes:The resident council interview was completed on 3/4/26 at 2:00 p.m. with four council members present. Residents 6, 30 and 41 indicated that Resident 25 on the 100 unit continually kept his television excessively loud and refused to close his door. The residents indicated they had complained to staff about the loud volume several times, but nothing had changed. Resident 6 indicated her room was next to his and the television would keep her up at night. Resident 41 indicated he had been Resident 25's previous roommate but had requested a different room due to the loud television. Resident 30 indicated they had been told by staff that the resident had the right to listen to his television at the volume he preferred, but she felt their rights were being infringed upon. There were no grievances related to the loud television volume in the past six months. Resident 25's record was reviewed on 3/5/26. A General Note, dated 12/3/25, indicated the resident had his TV on very loud and was educated by the nurse that it was disturbing the other residents. The resident turned his TV off. A General Note, dated 12/9/25, indicated the resident had his TV turned up to 100. He was redirected to turn it down several times but would turn the volume back up when the nurse left the room. A General Noted, dated 12/11/25, indicated the Social Service Director 1 (SSD 1) discussed moving the resident's bed to the back of the room and installing the TV to the side of the wall closer to him. He rejected the idea and did not see a problem with the volume. A General Note, dated 12/11/25, indicated the SSD had discussed the TV volume concerns with the resident's family member. They discussed checking into child control locks to limit the volume. Also discussed were the headphones they had provided but the resident refused to use. The family member wanted to get his hearing tested, but the resident had refused to go out to appointments. They discussed having the physician check his ears for wax buildup and having an audiology visit inhouse. A Psychological Evaluation, dated 12/16/25, indicated, .Staff report patient is very hard of hearing and has a tendency to turn his television up so high that it disrupts the unit and bothers other residents. Despite multiple conversations, patient's behavior has not changed The use of headphones was discussed, but the patient was not interested. The patient seemed legitimately unable to hear the TV at lower volumes. The summary indicated the resident would likely not benefit from psychotherapy due to hearing and cognitive impairments. An inhouse Audiology visit was completed on 12/18/25. The resident was found to have a moderate to profound hearing loss but did not want anything to do with hearing aids at that time. Headphones were discussed and he did not want those either. A General Note, dated 1/8/26, indicated Social Services had attempted to call the Ombudsman to discuss the concerns with the TV volume and disturbing other residents. A voicemail was left and the Ombudsman was e-mailed regarding the situation. Behavior monitoring was initiated on 1/29/26 and documented in the Treatment Administration Record. Interventions included to remind the resident that the volume should be turned down to about 50, offer headphones, and turn the TV off if the resident was sleeping. During an interview on 3/4/26 at 2:40 p.m., SSD 2 indicated he was aware of the concerns with (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 25's TV volume. They had provided him with headphones, but he would not use them, and he didn't like to keep the door closed. He was aware roommates had moved out due to the television volume. He had not completed an official grievance form but had been documenting interventions attempted in the resident's record. During an interview on 3/4/26 at 3:42 p.m., the Regional [NAME] President (RVP) indicated she was aware of the situation and had been involved with trying to resolve it. They had tried to contact the Ombudsman for assistance but had not heard back. They provided headphones, offered to move the TV closer but the resident declined all interventions. During an interview on 3/5/26 at 10:40 a.m., Resident 45, who resided on the 100 unit, indicated she heard the resident's TV all the time as it was very loud and irritating. She indicated she had complained to staff about it, but nothing had changed. During a follow-up interview on 3/5/26 at 9:15 a.m., the RVP indicated she had spoken to the resident's family member, and they were going to bring in a television with parental controls this weekend and were cooperative in trying to resolve this issue. She had also made a written agreement with the resident not to exceed a volume of 54 in the meantime as a reminder. She indicated staff didn't want to shut the resident's door against his wishes because they were fearful of infringing on his rights. The document, Social Services Policy and Procedure, was provided by SSD 2 on 3/4/26 and indicated, Miller's Merry Manor strives to address all resident concerns and complaints immediately to the satisfaction of the resident and/or family . and, I. Follow up with the involved party will be completed until the concern is resolved to the satisfaction of the resident and/or party and documented 410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to invite and hold care planning conferences for residents and/or their family members for 2 of 16 residents whose care plans were reviewed. (Residents 34 and 6)Findings include:1. During an interview on 3/3/26 at 3:22 p.m., Resident 34 indicated she had not been invited to or attended a care plan meeting. The record for Resident 34 was reviewed on 3/4/26 at 9:45 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, chronic kidney disease, major depressive disorder, dysphagia (difficulty swallowing), epilepsy, and stroke. The resident was admitted to the facility on [DATE]. The 1/22/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. A Facility Pre-Discharge Planning Assessment, dated 10/6/25, indicated the resident had her first care planning conference with the facility. There was no documentation the resident had a care plan conference after 10/6/25.During an interview on 3/5/26 at 10:15 a.m., the Social Service Director (SSD) indicated the first care plan meeting with the resident and her family was completed at the time of admission and documentation could be found in the pre-discharge planning assessment. During an interview on 3/5/26 at 1:15 p.m., the SSD indicated the resident had only had one initial care plan meeting when she was first admitted . She had notified the family about the next care conference but had not heard back from them. She was aware she could have held the meeting with just the resident. 2. During an interview on 3/2/26 at 2:04 p.m., Resident 6 indicated she was not aware of being invited to or attending a care plan meeting.The record for Resident 6 was reviewed on 3/4/26 at 9:21 a.m. Diagnoses included, but were not limited to, stroke, heart disease, osteoarthritis, and morbid obesity. The 12/11/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The Long Term Resident Care Plan Meeting Template indicated the resident had care planning conferences held on 1/7/25, 3/25/25, and on 10/3/25. The resident had attended all three meetings. There were no care plan meetings held between 3/25/25 and 10/3/25. There were also no care plan meetings held after 10/3/25. During an interview on 3/5/26 at 1:15 p.m., the Social Service Director indicated there were no other care planning conferences completed for the resident. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(d)(2)(B)

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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 observation, record review and interview, the facility failed to ensure bruises were assessed and monitored for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 34)Finding includes: During a random observation on 3/2/26 at 11:10 a.m., Resident 34 was observed with a reddish purple discoloration to the right forearm. The resident was not wearing geri sleeves (protective skin coverings for fragile skin) or long sleeves to either arm. During an interview on 3/4/26 at 11:50 a.m., the resident indicated staff did not always put her geri sleeves on her arms. During an observation on 3/5/26 at 9:31 a.m., CNA 2 was providing morning care for the resident. At that time, he removed both geri sleeves from her arms. There was a red and purple discoloration to the right forearm. The record for Resident 34 was reviewed on 3/4/26 at 9:45 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, chronic kidney disease, and stroke. The resident was admitted to the facility on [DATE]. The 1/22/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The Care Plan, dated 10/3/25, indicated the resident was on anticoagulant therapy for deep vein thrombosis (blood clot) prevention. The approaches were to monitor for signs and symptoms of bleeding such as bruising. A Physician's Order, dated 10/4/25, indicated Apixaban (an anticoagulant medication) 2.5 milligrams (mg), give one tablet by mouth two times a day. A Physician's Order, dated 12/22/25, indicated geri sleeves were to be on at all times except for bathing and hygiene. Skin checks were to be completed every shift. A Care Plan, dated 2/18/26, indicated the resident was at risk for developing bruises and skin tears. The approach was to apply geri sleeves. There was no documentation in the nursing notes regarding the bruise to the right forearm. The Nursing Weekly Assessments, dated 2/12, 2/19, and 2/25/26, indicated there was no documentation of any new bruising to the resident's arm. During an interview on 3/5/26 at 2:30 p.m., the Director of Nursing (DON) indicated there was a bruise on the resident's right forearm. There was no prior assessment of the bruise before 3/5/26. The current 4/23/24 Wound Assessment policy, provided by the DON on 3/5/26 at 2:30 p.m., indicated all non wound skin altercations would be completed on the nursing-new skin alteration assessment. The non wound area would be placed on the treatment administration record with instructions to monitor at least daily until healed. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 2 residents reviewed for accidents. (Resident 2)Finding includes:During a random observation on 3/3/26 at 11:35 a.m., Resident 2 was observed seated in her wheelchair in the doorway of her bathroom. The resident was wearing a pair of white tube socks. She was not wearing any shoes or non-skid socks. During an interview at that time, the resident indicated that she needed to go to the bathroom and that she was able to transfer herself. On 3/3/26 at 2:04 p.m., the resident was seated in her wheelchair in her room. Her feet were resting on the foot pedals of the wheelchair. The resident was wearing white socks and no shoes or non-skid socks. On 3/4/26 at 10:30 a.m., the resident was seated in her wheelchair. Her feet were resting on the foot pedals and she was propelling herself down the hall. The resident had a pair of tan fuzzy socks on over her white socks. The tan socks did not have a non-skid surface. At 11:30 a.m. and 1:45 p.m., the resident continued to have the tan socks on over her white socks. On 3/5/26 at 8:52 a.m., the resident was seated in her wheelchair in her room. The resident was wearing tan socks over her white socks. During an interview at that time, the resident indicated the tan socks she was wearing were her own and they did not have a non-skid surface. On 3/6/26 at 8:08 a.m., the resident was seated in her wheelchair in the dining room eating breakfast. The resident had on green fuzzy socks over her white socks. The green socks did not have a non-skid surface. The record for Resident 2 was reviewed on 3/4/26 at 11:08 a.m. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, left artificial hip joint, and difficulty walking. The Significant Change Minimum Data Set (MDS) assessment, dated 1/29/26, indicated the resident was cognitively intact. The resident required partial to moderate assistance with sit to stand transfers and toilet transfers. A Care Plan, dated 12/26/25, indicated the resident was at risk for falls due to a recent left hip replacement and generalized weakness. Interventions included, but were not limited to, encourage and assist with wearing non-skid footwear. During an interview on 3/6/26 at 10:55 a.m., the Director of Nursing indicated the resident should have been wearing either shoes or non-skid socks when up during the day. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure proper medication storage related to eye drops not labeled with directions for use and the physician's name, insulin pens used past their expiration date, and Tuberculin multi-use vials not labeled when opened, for 1 of 8 residents observed during medication administration, 2 of 2 medication carts, and 1 of 1 medication room observed. (Resident 39, the ICF and Rosewood medication carts, and the main medication room)Findings include: 1. During the medication administration observation on 3/3/26 at 10:21 a.m., RN 1 was preparing medications for Resident 39. She indicated she would be administering two eye drops to the resident, however, they would be 10 minutes apart. She removed the first eye drop of Brimonidine ophthalmic 0.1%. The bottle had a small label on it with the resident's name. There were no directions for use or the physician's name on the bottle. There was no original bag with a pharmacy-prepared label for the eye drops. During an interview on 3/3/26 at 11:03 a.m., RN 1 indicated the pharmacy labeled package for the eye drops was not available and could have been discarded. During an interview on 3/5/26 at 1:20 p.m., the Director of Nursing (DON) had no additional information regarding the labeling of the eye drops. The current 4/24/19 Medication Labels policy, provided by the DON on 3/5/26 2:30 p.m., indicated each prescription medication label included directions for use. 2. During an observation on 3/3/26 at 10:02 a.m., of the ICF medication cart, there was a Lantus insulin kwik pen with an open date of 1/26/26. The sticker on the pen indicated to discard after 28 days. During an interview at that time, LPN 2 indicated the pen should have been discarded. 3. During an observation on 3/5/26 at 10:07 a.m., of the Rosewood medication cart, there was a Lantus insulin kwik pen with an open date of 2/3/25. The sticker on the pen indicated to discard after 28 days. During an interview at that time, RN 1 indicated the pen should have been discarded. During an interview on 3/5/26 at 1:20 p.m., the Director of Nursing (DON) indicated the insulin pens were to be discarded after 28 days. 4. During an observation on 3/5/26 at 2:00 p.m., the medication room was observed. There was one opened multi-use vial of Tuberculin (TB testing solution) with no date as to when it was opened. During an interview at that time, the Director of Nursing indicated the tuberculin vial should have been dated after opening. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(k)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-25(k)(5)410 IAC (Indiana Administrative Code) 16.2-3.1-25(k)(6)

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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. Based on observation and interview, the facility failed to ensure infection control practices were in place and implemented related to not wearing personal protective equipment (PPE) in enhanced barrier precaution rooms, and failing to disinfect multi-use equipment during random infection control observations. (Residents 57 and 39) Findings include:1. During an intravenous (IV) antibiotic medication administration observation for Resident 57 on 3/3/26 at 12:55 p.m., LPN 1 was observed with the IV antibiotic ball of Cefepime 2 grams. The LPN entered the resident's room and performed hand hygiene with soap and water. She donned clean gloves to both hands and raised the resident's shirt sleeve to gain access to the single lumen PICC (peripherally inserted central catheter) line. She flushed the single lumen with saline and connected the antibiotic. At that time, she helped the resident reposition herself in bed by placing pillows under her leg. The LPN removed her gloves and washed her hands with soap and water. She did not don an isolation gown prior to the administration of the IV antibiotic. At 2:38 p.m., LPN 1 entered the resident's room to disconnect the IV antibiotic. She performed hand hygiene and donned a clean pair of gloves to both hands. She removed the IV tubing, flushed the port with saline followed by Heparin (an anticoagulant), removed her gloves and performed hand hygiene. She did not don an isolation gown prior to disconnecting the IV antibiotic from the PICC line. During an interview on 3/3/26 at 2:45 p.m., LPN 1 indicated she was aware the resident was in enhanced barrier precautions and she was supposed to wear an isolation gown while administering and removing the IV antibiotic. During an interview on 3/5/26 at 1:20 p.m., the Director of Nursing indicated nursing staff were required to wear PPE when administrating the IV antibiotic. 2. During the medication administration observation on 3/3/26 at 10:21 a.m., RN 1 was preparing medications for Resident 39. She entered the resident's room with the multi-functional blood pressure machine. She wrapped the cuff around the resident's arm and placed the pulse oximeter on her finger. After she checked the resident's vital signs she administered the resident's medications. She left the room and returned the blood pressure machine to the space by the wall and plugged it in. She did not wipe down the blood pressure machine or sanitize it after she had used it. She performed hand hygiene, signed the medications out on the computer, and proceeded onto the next resident.During an interview on 3/3/26 at 11:03 a.m., RN 1 indicated she did not clean the multi-function blood pressure machine after use. During an interview on 3/5/26 at 1:20 p.m., the Director of Nursing (DON) indicated the blood pressure machine was to be wiped down and sanitized after each use. There was no facility policy for cleaning the multi-function blood pressure machine. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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F 0729 Level of Harm - Potential for minimal harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure CNAs had a current and valid certificate to work in the facility for 1 of 15 CNA records reviewed. (CNA 1)Finding includes:The employee files were reviewed on [DATE] at 3:00 p.m. The certification for CNA 1 expired on [DATE].The staff schedule indicated CNA 1 worked on the following days since her certification expired: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].During an interview on [DATE] at 3:14 p.m., the Human Resources Director indicated CNA 1's certification expired, and she was going to help her fix it.During an interview on [DATE] at 10:22 a.m., the Corporate Administrator indicated there was a system in place to check certifications monthly, but CNA 1 was missed. 410 IAC (Indiana Administrative Code) 16.2-3.1-14(f)