STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155574	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	500 Walkerton Tr Walkerton, IN 46574

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident's right to be informed and involved in care planning was upheld for 1 of 3 residents reviewed (Resident O).Findings include:A report, dated 9/11/25, indicated Resident O had been prescribed opioid pain medication to be given routinely every 4 hours. The resident had taken the opioid as prescribed and alleged they had experienced withdrawal symptoms when they requested the medication be decreased in dose and frequency.During an interview, on 10/8/25 at 12:36 P.M., with Resident O she indicated she had had a short-term stay at the facility in August 2025 for rehabilitation following a right knee replacement and had since been discharged home. She indicated, during her stay, she was prescribed pain medication which was to be taken every 4 hours. Resident O indicated she was told by a nurse, she should take the medication as prescribed to keep ahead of the pain. She indicated she had missed a dose of pain medication, one day during her stay, and started to feel sick. She was given the pain medication 2 hours after the missed dose and she felt better immediately. She realized she was addicted to the pain medication and told staff she was concerned. A nurse notified the physician and he reduced the frequency of the opioid medication to every 12 hours. She indicated after the frequency of the medication was reduced, she began to have worsening symptoms of withdrawal. She indicated she had experienced chills, hot flashes, runny nose, pain, anxiety, nausea, vomiting, tremors, watery eyes, decreased appetite and difficulty sleeping. Another nurse had explained to her that she should have been tapered off the pain medication more slowly to avoid the withdrawal symptoms. When asked, she indicated she had not known why she was to take the pain medication every 4 hours around the clock and had not been told about the potential side effects and withdrawal symptoms she could experience when the pain medication was decreased. She indicated the doctor, Nurse Practitioner (NP), nor the nursing staff had involved her in the decision to use opioids routinely to treat her right knee pain nor was she offered a non-medication treatment to deal with the pain. On 10/8/25 at 12:55 P.M., Resident O's record was reviewed. Diagnoses included right artificial knee joint replacement. A hospital record, dated 8/6/25, indicated the resident was admitted to the hospital on recommendation of the orthopedic surgeon following right knee replacement with severe post-operative pain. She was discharged to the facility on 8/9/25 after her pain had improved and she was no longer requiring intravenous morphine for her pain. She had been prescribed and received a prescription for Percocet (opioid) 10-325 mg tablets-1 tablet every 6 hours as needed for moderate to severe pain for 12 doses. She had been given a dose of the Percocet prior to leaving the hospital. The care plans for Resident O indicated she was had been admitted to the facility for rehabilitation and would be discharged back home after completion of her therapy. Her plans indicated she was to receive occupational therapy for assistance with transfers and self-care, required supervision with activities of daily living, had no cognitive impairments and had the potential for pain due to her recent right knee replacement.A Skilled Nurse Assessment, dated 8/10/25 at 12:40 A.M., indicated the resident's pain level on 8/9/25 at 11:03 P.M. was rated at a 9 out of 10 with 10 being the worst pain felt. She was given Percocet 10-325 mg tablet-1 tablet by mouth for the right knee pain. The resident indicated her pain was constant but had not affected her sleep or ability to do day to day activities. Following the administration of the Percocet, Resident O indicated effectiveness with her pain level as it had decreased to a 2 out of 10.A Skilled Nurse Assessment, dated 8/10/25 at 10:07 a.m., indicated Resident O rated her pain at a 5 out of 10. The assessment indicated the interventions for pain control included the use of Percocet (Opioid), ice machine, and repositioning. A physician's order, dated 8/10/25, was to give Percocet 10-325 mg tablets-1 tablet every 4 hours routinely for pain.There was no documentation completed indicating the reason for changing the order for the Percocet from every six hours as needed to every 4 hours routinely. There was no documentation indicating Resident O had been notified of the reason for change in her opioid medication nor the risks vs benefits of taking opioid medication routinely, including the risk for tolerance and addiction. During an interview, on 10/8/25 at 2:00 P.M., Registered Nurse (RN) 2 indicated on 8/10/25, she had assessed Resident O and observed her in severe distress from her right knee pain. She had contacted the NP and obtained the order changing the Percocet 10-325 mg tablets to be given every 4 hours in an attempt to help relieve the resident's pain. When asked, she indicated she had not spoken with the resident about the plan to give her opioid/pain medication every 4 hours nor had she explained the risks vs benefits of taking routine opioid medication. She indicated she had not documented notification to the NP or the change in orders in the clinical record.On 10/8/25 at 2:15 P.M., the Director of Nursing (DON) and Assistant Director of

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure a resident was free from physical abuse for 2 of 3 residents reviewed. (Resident S and U). This deficient practice resulted in a hand injury and extensive bruising for 1 of 3 residents. (Resident S) Findings include:A report, dated 9/29/25, alleged Resident U had several physical altercations with Resident S due to Resident S wandering into her room. It was alleged there had been no interventions put in place to protect Resident S and staff had been instructed to not document these altercations. It was alleged during one of the altercations, Resident U had caused bruises on Resident S. Resident S had been kicked, punched, and swung at by Resident U, who had allegedly had similar behaviors at another nursing facility prior to being admitted . On 10/6/25, from 11:20 A. M. to 11:40 A.M., residents were observed on the secured memory care unit (MCU). There were 11 female residents on the secured unit. Two residents, Resident S and an unknown resident, were observed walking throughout the hall and dining/activity room and the remaining residents were seated at a large dining table having a snack. Resident S had a steady gait and required no assistance to ambulate. She wore a blank expression on her face, made eye contact but was non-verbal. She was observed leading the unknown resident down the hallway where both residents entered Resident U's room, whose room door was open. There was no signage or stop sign across Resident U's open door to deter entrance into the room. Both residents shortly exited the room and continued walking the hall back towards the dining room. Resident S was observed on 10/7 and 10/8/25 at various times, walking up and down the hallway and dining room area of the MCU. She was non-verbal, expressionless, and walked around with no sense of purpose. She was not observed to be aggressive or intrusive. On 10/6/25 at 12:30 P.M., Resident S's record was reviewed. Diagnoses included early-onset Alzheimer's and severe dementia without behaviors. She was receiving hospice services for her severe dementia.The current care plan for resident S indicated she had severely impaired cognition, was non-verbal, and required assistance with her activities of daily living due to her severe dementia. A care plan, dated 9/26/24, indicated she had behaviors related to her diagnoses and staff were to monitor the resident for anxious behaviors such as pacing to the point of exhaustion if it caused her distress. The care plans did not indicate Resident S wandered frequently into Resident U's room nor were there interventions to prevent the obtrusive wandering. The care plan did not indicate Resident S had been involved in physical altercations with Resident U when she had wandered into her room. A Nursing Progress note, dated 9/9/25 at 4:30 P.M., indicated Resident S had a 1-centimeter (cm) skin tear to her left hand due to Resident U hitting her hand. Resident S's family and staff had witnessed the altercation between Resident S and Resident U. A Social Service note, dated 9/10/25 at 5:36 P.M., indicated the Social Services Designee (SSD) had checked on Resident S, who was observed walking about the MCU as usual. Staff indicated Resident S had had a good day and there had been no concerns voiced related to the resident's mood. On 9/12/25 at 9:40 A.M., a physician's order was obtained to cleanse the skin tear to Resident S's left hand with normal saline and cover with a dry dressing two times per week. There was no further documentation completed regarding the resident-to-resident altercation between Resident S and U, nor had there been any changes made to Resident S or Resident U's care plans to prevent further altercations. Resident S's care plan, dated 9/12/25, indicated she had a skin tear to her left hand and was at risk for complications. Interventions included monitoring the area for complications, completing treatment as ordered and notifying the physician as needed. A New Behavior Initial Assessment form, dated 9/11/25 at 1:59 P.M., indicated Resident U had been observed sitting in her room when a peer came to her doorway. Resident U aggressively made contact with the peers legs and feet. The peer lost her balance and was pushed back. The two residents were separated and Resident U eventually calmed down. Resident U's family was notified, and the family indicated the resident had a history of being physically abusive to her peers. The peer was confirmed to be Resident S. There was no documentation completed in Resident S's record or any assessment completed of her injuries which had resulted from the physical altercation with Resident U. There were no changes made to the care plan to prevent further altercations and injuries from occurring. A Nursing Occurrence Initial Assessment form, dated 9/18/25 at 11:57 A.M., indicated Resident S was observed with scattered bruising to both of her lower legs. Her right lower leg had 5 bruises measuring: #1- 4 cm x 2 cm; #2- 2 cm x 2 cm; #3- 2.5 cm x 2 cm; #4- 3 cm x 2 cm and #5- 5 cm x 4 cm. The left lower leg had 3 bruises measuring: #1- 13 cm x 7 cm; #2- 1 cm x 2 cm and #3- 1 cm x 1.5 cm. There was no description of the color of the bruises or any assessment of pain from the bruises. The physician and family were notified

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure allegations of physical abuse were reported for 2 of 2 cognitively impaired residents reviewed for abuse (Resident S and Resident U).Findings include:A report, dated 9/29/25, alleged Resident U had several physical altercations with Resident S due to Resident S wandering into her room. It was alleged there had been no interventions put in place to protect Resident S and staff had been instructed to not document these altercations. It was alleged during one of the altercations, Resident U had caused bruises on Resident S from kicking, punching, and swinging at her. On 10/6/25 at 12:30 P.M., Resident S's record was reviewed. Diagnoses included early-onset Alzheimer's and severe dementia without behaviors. A Nurses Progress note, dated 9/9/25 at 4:30 P.M., indicated Resident S had a 1-centimeter (cm) skin tear to her left hand due to Resident U hitting her hand. Resident S's family and staff had witnessed the altercation between Resident S and Resident U. There was no follow up documentation, investigation completed or reporting of the altercation as required. A Nursing Occurrence Initial Assessment form, dated 9/18/25 at 11:57 a.m., indicated Resident S was observed with scattered bruising to both lower legs. Her right lower leg had 5 bruises measuring: #1- 4 cm x 2 cm; #2- 2 cm x 2 cm; #3- 2.5 cm x 2 cm; #4- 3 cm x 2 cm and #5- 5 cm x 4 cm. The left lower leg had 3 bruises measuring: #1- 13 cm x 7 cm; #2- 1 cm x 2 cm and #3- 1 cm x 1.5 cm. There was no description of the color of the bruises or assessment of pain from the bruises. There was no investigation, incident reporting or follow up documentation completed for the cause of extensive bruising to Resident S's legs. A New Behavior Initial Assessment form, dated 9/19/25 at 11:00 p.m., indicated Resident U had been observed in the hallway in her wheelchair when Resident S walked by her. Resident U began yelling, kicking and hitting the other resident several times until staff intervened. The Administrator was notified of the altercation, but there was no documentation of an investigation into the altercation nor was the incident reported as required by State and Federal regulations. A Nursing-Occurrence Initial Assessment form, dated 9/25/25 at 2:25 p.m., indicated Resident S was observed with a mark on her face below her left eye. The form indicated it was an isolated incident and no further information was documented. There was no documentation completed indicating the injury of unknown origin had been investigated, the cause determined, and reporting completed as required.During an interview, on 10/8/25 at 1:30 P.M., the Administrator indicated she had not been informed of the extensive bruising observed on Resident S's legs on 9/18/25. She had not been notified of the circumstances surrounding the 4 alleged altercations between Resident U and Resident S. She indicated there should have been an investigation into the altercations and results of investigation reported to State and Federal agencies as required. A current policy, titled Abuse Prohibition, Reporting, and Investigation, was provided by the Administrator on 10/6/25 at 12:00 P.M. The policy indicated all residents had the right to be free from abuse including physical abuse which includes hitting, kicking, slapping, biting, and punching. Abuse was defined as being willful with actions done deliberately. The policy indicated alleged abuse and unusual occurrences must be reported to the Administrator immediately. The facility was to report allegations of abuse/unusual occurrences with 2 hours of discovery if the resident had visible injuries or 24 hours when no injuries were visible. An investigation was to occur immediately and results of the investigation reported to the Indiana Department of Health within 5 days of the initial report.This Citation relates to Intake 2629854.3.1-28(c)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure an effective behavior care plan, behavior monitoring and documentation was completed related to dementia for 1 of 3 residents reviewed for dementia needs. (Resident U). Findings include:A report, dated 9/29/25, alleged Resident U had several physical altercations with another resident who would wander into her room. It was alleged there had been no interventions put in place to protect the other resident and staff had been instructed to not document these altercations. It was alleged during one of the altercations, Resident U caused bruises on the other resident from being kicked, punched, and swung at. Resident U allegedly had similar behaviors at another nursing facility prior to being admitted . On 10/6/25 at 12:12 P.M., Resident U's record was reviewed. Diagnoses included dementia, psychotic disorder with delusions, depression, and sleep disorder. A quarterly Minimum Data Set (MDS) assessment, dated 8/19/25, indicated Resident U had moderately impaired cognition, had no mood indicators but had had physical behaviors towards others 1-3 days during the assessment, required supervision to partial assistance with her activities of daily living and used a wheelchair for mobility which she propelled herself. The current care plans for Resident U included the following: -Resident U displayed mood issues of excessive nervousness and worrying. She had behaviors of becoming territorial of her space and hitting/kicking staff when they attempted to enter her room or provide care. Interventions included monitoring her behaviors of hitting/kicking staff and excessive nervousness/worry; when behaviors occurred, staff were to reapproach her at later time; offer snack/drink; offer diversional activity like watching TV; offer to help resident call her daughters; talk with her about past interests; and offer 1:1 conversation/assurance. - The resident had confused thoughts and at times, delusions which were not distressing to her and didn't interfere with her care. Interventions included: staff were not to argue with or correct the resident when she had confused thoughts; if upset or distressed, check for unmet needs; reintroduce self with each interaction with resident; and break activities into manageable subtasks and explain procedures prior to providing care. - Resident U resided on the Memory Care Unit due to her dementia and the need for dementia programming. Interventions included: provide specialized programming. The clinical record indicated Resident U had been admitted to the facility from a sister facility, owned by the same corporation. Records from the sister facility indicated the resident had a diagnosis of dementia with other behavioral disturbances. There were no other records available, indicating what the behavioral disturbances the resident had displayed at her previous facility had been.On 10/6/25, from 11:20 A.M. to 11:40 A.M., residents were observed on the secured memory care unit (MCU). There were 11 female residents. Resident U was observed seated at the dining room table participating in an activity and snack. Two ambulatory residents were observed walking throughout the hall and dining/activity room. The two ambulatory residents wandered down the hall and walked into Resident U's room. The room door for Resident U's room was open. There was no signage or stop sign across the open door to deter entrance into the room observed. Both residents shortly exited the room and continued walking the hall back towards the dining room.On 10/8/25 at 11:18 A.M., Resident U was observed outside the doorway of her room, seated in her wheelchair. An unknown resident walked towards the doorway of Resident U's room and walked in. She picked up a hat from a chair and brought it to Resident U. Resident U indicated other residents always came into her room and picked things up because her room was so nice. When asked if it bothered her when other residents came into her room uninvited, she indicated it did not. A nurse progress note, dated 9/9/25 at 6:32 p.m., indicated Resident U's daughter had been notified of the resident hitting another resident's hand causing a skin tear. The Administrator and Director of Nursing (DON) had also been notified of the event. Refer to F600.There was no further documentation completed for the altercation occurring between Resident U and a peer. There were no changes made to the care plan and no interventions put in place to prevent further altercations from occurring. A New Behavior Initial Assessment form, dated 9/11/25 at 1:59 p.m., indicated Resident U had been observed sitting in her room when a peer came to her doorway. Resident U aggressively made contact with the peers legs and feet. The peer lost her balance and was pushed back (by Resident U). The two residents were separated and Resident U eventually calmed down. Resident U's family was notified, and the family indicated the resident had a history of being physically abusive to her peers.A New Behavior follow-up Assessment form, to be completed every shift for 72 hours after the identification of new behavior, dated 9/11/25 at 9:24 p.m.; 9/12/25 at 6:14 a.m., 3:17 p.m., and 8:57 p.m.; 9/13/25 at 6:07 a.m. 1:43 p.m., and 8:43 p.m.; 9/24/25 at 2:36 p.m. and 7:57 p.m. all indicated Resident U had had no behaviors