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	12/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to develop a comprehensive person-centered care plan for activities for 1 of 15 residents reviewed for care plans (Resident 5) Findings included:1.The clinical record of Resident 5 was reviewed on 12/3/2025 at 2:02 P.M. The resident's diagnoses included, but were not limited to: abdominal aortic aneurysm without rupture, adult failure to thrive, emphysema, difficulty in walking and pressure ulcer of the right hip. A Quarterly Minimum Data Set (MDS) assessment, dated 10/30/2025, indicated the resident was cognitively intact. An admission MDS assessment, completed on 5/15/2025, indicated it was very important for Resident 5 to do her favorite activities but the assessment had not identified her favorite activities.A Physician's Order, dated 5/8/2025, indicated Resident 5 could participate in an individual activity program according to the resident's care plan.Resident 5's clinical record lacked an individualized care plan related to activities.During an interview, on 12/4/2025 at 1:45 P.M., the Activity Director indicated there was no individualized care plan related to activities for Resident 5. The Activity Director indicated Resident 5 had been very resistant to participating in any group or individual activities but she had indicated she enjoyed drinking Coke or Pepsi and had enjoyed eating fresh fruit. The Activity Director indicated she should have included these activities in Resident 5's activity care plan.On 12/5/2025, at 11:35 A.M., the Assistant Director of Nursing provided a policy titled, Care Plan Development & Review, dated 1/24/2020 and indicated the policy was the one currently used by the facility. The policy indicated .The comprehensive care plan is designed to .Build on the resident's strengths .Reflect treatment goals and objectives in measurable outcomes .show evidence of efforts to find alternative means to address problems when resident is refusing treatment .3.1 - 35 (a)

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to follow the treatment plan for a resident with a pressure injury and failed to notify the provider and responsible party of a worsening pressure injury for 1 of 2 residents who were reviewed for pressure injuries. (Resident 15)Finding includes:Resident 15 was observed in bed and was not wearing a palm guard on her left hand during the following observations: 12/1/2025 at 10:44 A.M., 12/1/2025 at 2:15 P.M. and 12/3/2025 at 9:44 A.M.Resident 15's record review was completed on 12/3/2025 at 10:45 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, contracture of the left elbow and left hand. A Quarterly Minimum Data Set assessment, dated 11/12/2025, indicated Resident 15 had severely impaired cognition and had one unhealed stage 2 pressure injury. A current Care Plan initiated on 5/21/2025 indicated Resident 15 was at risk of complications related to her left-hand contracture. Resident 15's Care Plan had a goal, initiated on 5/21/2025, indicating the resident would not have complications related to her left-hand contracture. Interventions to the Care Plan included, but were limited to: wear palm guard in left hand while awake (initiated on 08/05/2025) and splint to left hand during sleeping hours (initiated on 8/5/2025). Resident 15's Wound: Pressure Injury Assessments for her left hand, dated 11/19/2025 and 11/26/2025, indicated a pressure injury had measured 0.4 cm long by 0.7 cm wide by less than 0.1 cm deep. The pressure injury was marked as healing on both the 11/19 and 11/26/2025 assessments. Resident 15's Wound: Pressure Injury Assessment for her left hand, dated 12/2/2025, indicated the pressure injury measured 0.5 cm long by 0.7 cm wide by less than 0.1 cm deep. The pressure injury was marked as not healing on the assessment. Resident 15's record lacked documentation to indicate the treatment for the pressure injury had been updated or a notification of change had been sent to the resident's physician or family member. The record also lacked documentation Resident 15 had refused to wear her palm guard or splint in October 2025, November 2025 or December 2025.During an interview on 12/3/2025 at 10:10 A.M., RN 2 indicated Resident 15 was not wearing a palm guard on her left hand because she was non-compliant. RN 2 was not able to show the refusal of the palm guard in Resident 15's record for 12/3/2025. RN 2 indicated Resident 15's record should had contained a note indicating the physician had been notified that the resident had refused to wear the palm guard.During an interview on 12/3/2025 at 1:50 P.M., the [NAME] President of Operations (VPO) indicated Resident 15's pressure injury had been assessed and found to have worsened, but the physician and family had not been notified of the decline in the wound.During an interview on 12/4/2025 at 10:50 A.M., the Director of Therapy (DOT) indicated Resident 15 had been working with therapy but had been non-compliant with her palm guard during the day and her hand splint during the night. The DOT indicated nurses had reported the resident had been non-compliant with the palm guard and splint and she had witnessed Resident 15 take off the palm guard during therapy. The DOT indicated the treatment plan for Resident 15 was for her to wear a palm guard during the day and a splint at night. The DOT indicated the palm guard had been ordered on 10/28/2025 and was delivered to the facility on [DATE].During an interview on 12/5/2025 at 11:35 A.M., the Assistant Director of Nursing (ADON) indicated if a pressure injury worsened, the provider was to be notified and new orders for different treatment should have been obtained. The ADON indicated the facility did not have for have a policy for following the plan of care or physician orders. She indicated that was considered part of the Standards of Nursing.On 12/5/2025 at 11:35 A.M., the ADON provided an undated policy title, Physician and Family Notification of Condition Changes and indicated it was the policy currently used by the facility. The policy indicated, . II. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan. V. Document the information reported to the physician in the nurses notes including the time and date of notification. VI. Document the response from the physician in the nurses notes. 4. Family notification A. Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan.3.1-40

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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 observations, interviews, and record reviews, the facility failed to follow care plan interventions related to fall prevention for 1 of 5 residents reviewed for accidents. This resulted in the resident incurring a fall from her wheelchair and sustaining facial bruising and two skin tears (Resident 9) In addition, the facility failed to ensure supervision was provided related to the use of an electrical power strip and coffee maker in 1 of 5 residents reviewed for accidents. (Resident 1) Findings include: 1.The clinical record for Resident B was completed on 12/4/2025 at 10:00 A.M. Diagnosis for Resident B included, but was not limited to, history of falling. A nursing progress note, dated 11/4/2025, indicated Resident B was found lying face down on the floor in front of her wheelchair on 11/4/2025 at 5:45 P.M. by a staff member. Resident B's face was bruised, and she had sustained 2 skin tears. A current Care Plan Problem, related to falls included an intervention initiated 7/2/2024. The intervention indicated Resident B was to be assisted into her recliner or into bed when returned to her room. During an interview on 12/4/2025 at 11:03 A.M., Resident B's daughter indicated that on 11/4/2025 she had been visiting when her mother indicated she wanted to go to bed. The daughter had pushed the call light, an agency Certified Nurse Assistant (CNA) had answered the light and indicated he would be back with linens to put the resident to bed. The daughter then left the facility. She received a phone call on 11/4/2025 at 8:06 P.M. from the facility and was informed her mom had fallen from her wheelchair. The daughter further indicated that she understood that her mom would not be left in her room unless she was in bed or her recliner due to a previous fall. She indicated she had only left her because the CNA indicated he would be right back to put her to bed. During an interview on 12/5/2025 at 12:13 P.M., the DON indicated CNA's had assignment sheets that informed them of the care each resident required. A review of the assignment sheet for Resident B indicated she was not to be left in her room alone in her wheelchair and was to be put in bed if she was being left alone. On 12/5/2025 at 11:35 A.M. the ED provided a current policy dated 1/24/2020, and titled, Care Plan Development and Review. The policy indicated, .5. B. Nurse aides are advised of the residents care plan focuses and interventions that are within their scope of practice via assignment sheets and/or POC (plan of care) located in EMR (electronic medical record) 2. During an observation on 12/1/2025 at 10:57 A.M., Resident 1 had an electrical power- strip plugged in above his sink and resting on the sink counter with an electric coffee pot plugged into it and turned on. During an interview on 12/1/2025 at 10:57 A.M., Resident 1 indicated he had been permitted to have the coffee pot and make coffee whenever he wanted. During an observation on 12/3/2025 at 9:03 A.M., Resident 1 had an electrical power strip plugged in above his sink and sitting on the sink counter with a coffee pot plugged into it and turned on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's record review was completed on 12/3/2025 at 9:30 A.M. Diagnoses included, but were not limited to osteomyelitis of the left foot and left ankle, below the knee amputation of right leg, type two diabetes and major depressive disorder. Resident 1's cognition was intact. Resident 1's record did not have a Care Plan indicating he was permitted to have a coffee maker in his room. During an interview on 12/3/2025 at 1:55 P.M., the Assistant Director of Nursing indicated Resident 1 should not have a power strip on the counter next to his sink and should not have had a coffee maker. in his room. During an interview on 12/5/2025 at 1:05 P.M., the Executive Director indicated the facility did not have a policy related to the use of small kitchen appliances in resident rooms or the use of power strip electrical outlets in resident rooms. 3.1-45(a) 3.1-45(a)(2)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure employee certifications were active for 2 of 28 employees whose certifications were reviewed. This has the potential to effect 45 of the 45 residents who resided in the facility. (Employee 3 & 4)Findings Include:A review of the employee certifications was completed on [DATE] at 11:00 A.M. Employee 3, a CNA (Certified Nursing Assistant) had a hire date was [DATE]. Employee 3's CNA certification had expired on [DATE].A review of the facility schedule indicated Employee 3 had worked on the following recent dates at the facility as a CNA: 11/6, 11/10, 11/11, 11/13, 11/15-18, 11/20, 11/21, 11/24, 11/25, 11/30, 12/1 and [DATE].During an interview on [DATE] at 11:50 A.M., Employee 3 indicated she had not known her CNA certification had expired on [DATE].2. Employee 4 was hired on [DATE].Employee 4's QMA (Qualified Medication Aide) certification had expired on [DATE] and her CNA certification had expired on [DATE].A review of the facility's recent nursing schedule indicated Employee 4 had worked on the following dates at the facility as a QMA: 11/6, 11/7, 11/8, 11/11, 11/18, 11/20, 11/21, 11/22, 11/25, 11/28, and [DATE] and worked as a CNA: 11/13, 11/23, and [DATE].During an interview with the Director of Nursing (DON), on [DATE] at 1:10 P.M., the DON indicated she had called Employee 4 and Employee 4 indicated she was not aware of her expired certifications.During an interview on [DATE] at 12:40 P.M., the Executive Director indicated the person responsible for employee certifications was the Director of Staff Development and she had left the facility several months ago.On [DATE] at 1:20 P.M., the [NAME] President of Operations supplied a document titled, Director of Staff Development Task List and indicated it was the list currently used by the facility to ensure certifications were active. The task list indicated, .Monthly.Check CNA and QMA certifications are renewed timely.This citation relates to intake 2621113 and 2564067.3.1-14