STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155579	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller's Merry Manor	7440 N County Road 825 E Hope, IN 47246

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. Based on record review and interview, the facility failed to provide appropriate assistance to prevent an avoidable accident for 1 of 3 residents reviewed for accidents hazards. This deficient practice resulted in the resident acquiring a left clavicle (collarbone) fracture, left rib fracture, and sub-capital fracture (the femoral neck breaks near the head of the femur, inside the joint capsule) of the right hip. (Resident D) Findings include:The clinical record for Resident D was reviewed on 05/19/2026 at 10:36 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/09/2026, indicated the resident was severely cognitively impaired and required extensive assistance of staff for mobility. The resident had and impairment on one side of upper and lower extremities. The resident's diagnoses included, but were not limited to, stroke (a medical emergency that occurs when blood flow to an area of the brain is cut off or a blood vessel in the brain bursts), aphasia (a language disorder that affects a person's ability to communicate), and anxiety (feeling of uneasiness). A Facility Incident Report, dated 05/14/2026, indicated Resident D sustained fractures related to a fall from his bed. A Hospital Document, dated 05/14/2026 at 10:22 A.M., indicated the resident had a left clavicle (collarbone) fracture, left rib fracture, and sub-capital fracture of the right hip. The resident also had a superficial hematoma (collection of blood that has pooled outside of a blood vessel, typically due to injury) over the parietal region (located at the upper back and crown of the skull) of the scalp. A Progress Note, dated 05/14/2026 at 3:22 A.M., indicated Resident D was turned on his right side while being changed by a Certified Nursing Assistant (CNA). Licensed Practical Nurse (LPN) 2 left the room to gather supplies. Upon return the CNA was observed outside of Resident D's room. Upon returning to Resident D's room the resident was found lying on his back on the floor. The resident was observed to have a 7-centimeter (cm) x (by) 6 cm hematoma on the back left of his head. Resident D was sent to the emergency room. During an interview, on 05/19/2026 at 10:05 A.M., Resident D indicated that he fell out of bed and hurt his side. There were no staff in the room when he fell. During an interview, on 05/19/2026 at 1:47 P.M., LPN 2 indicated she was informed by CNA 3 that Resident D's dressing needed changed. LPN 2 and CNA 3 went into Resident D's room and began to provide hygiene care. The bed was waist high to provide care. LPN 2 needed more supplies and left the room. When she left the room CNA 3 was still in the room. Resident D was on his right side on the edge of the bed with CNA 3 holding onto him. When LPN 2 came out of the supply room CNA 3 was standing outside of the resident's room in the hallway. They both went back into Resident D's room together and found the resident lying on his back on the floor. Resident D did not have any mobility in his right arm and had very limited mobility in his right leg. A Witness Statement, provided by the Administrator on 05/19/2026 at 3:42 P.M., indicated CNA 3 indicated she was providing care for Resident D on 05/14/2026 when the nurse went to get a larger dressing for the resident, she stayed in the room with the resident when the nurse left the room. After waiting a few minutes, she left the room to find the nurse. She left the resident turned on his side in the bed. When both staff returned to room, Resident D was on the floor next to his bed. During an interview, on 05/19/2026 at 2:45 P.M., CNA 4 indicated Resident D had very limited mobility of his right leg and no mobility of his right arm. The resident required two physical staff members for mobility while in bed. The resident required a full (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	body mechanical lift for transfers. During an interview, on 05/19/2026 at 3:04 P.M., Clinical Support Nurse 6 indicated they did not have a facility policy for accidents. The current facility policy, titled Nursing Assistant - Certified Job Title, with a revision date of 11/03/2019, was provided by the Administrator on 05/19/2026 at 3:09 P.M. The policy indicated, .To assist the professional nursing staff in continually rendering resident care while affording dignity, comfort, and safety to those residents . This deficiency was corrected on 05/18/2026, after the facility assessed all residents care plans for falls; provided education to all staff related to fall management, to include dependent resident with bed mobility; and ongoing audits to monitor for fall prevention and was therefore Past Noncompliance. This citation relates to Intake 3014884. 410 IAC (Indiana Administrative Code) 3.1-45(a)(1)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to have medications available to administer as prescribed to 1 of 3 residents reviewed for pharmacy services. (Resident E) Findings include: The clinical record for Resident E was reviewed on 05/19/2026 at 1:12 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/18/2026, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes mellitus (a chronic metabolic disease characterized by high blood sugar resulting from defects in insulin), non-Alzheimer's dementia (cognitive disorders caused by diseases other than Alzheimer's), and Parkinson's Disease (a progressive neurological disorder that affects the nervous system and parts of the body controlling movement). A Physician's Order, dated 05/04/2026 and discontinued date of 05/18/2026, indicated Resident E was to receive Trulicity Subcutaneous (under the skin) solution Autoinjector 4.5 milligram (mg)/0.5 milliliter (ml) one time a day every Monday for Diabetes. The May 2026 Electronic Medication Administration Record (EMAR) indicated Resident E was not administered Trulicity 4.5mg/0.5ml on Monday May 11th, or Monday May 18th. An EMAR Medication Note, dated 05/11/2026 at 10:17 A.M., indicated Resident E's Trulicity medication was not available. An EMAR Medication Note, dated 05/18/2026 at 08:00 A.M., indicated Resident E's Trulicity medication was not available but on order. During an interview, on 05/19/2026 at 3:14 P.M., Licensed Practical Nurse (LPN) 5 indicated she was Resident E's nurse on 05/11/2026 and she knew the resident was out of Trulicity but forgot to notify the pharmacy or physician about being unable to administer the medication. During an interview, on 05/19/2026 at 2:36 P.M., LPN 7 indicated whenever a medication was unavailable, she would contact the pharmacy to have the medication delivered as soon as possible. The pharmacy could deliver within two hours, or they were at the facility every day in the evenings for routine deliveries. All medications should have been administered as ordered, and if they were not available from the pharmacy the physician should be notified. During an interview, on 05/19/2026 at 3:04 P.M., Clinical Support Nurse 6 indicated if a medication that was ordered was not available the nurse should contact the pharmacy to have the medication delivered the same day. If not available, they should contact the physician for additional orders. The nursing staff did not follow protocol for the resident's medication. The current undated facility policy titled, Unavailable Medications, was provided by the Administrator on 05/19/2026 at 2:49 P.M. The policy indicated, .The facility must make every effort to ensure that medications are available to meet the needs of each resident . 410 IAC (Indiana Administrative Code) 3.1-25(b)