STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. BUILDING 00 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00459383. Complaint IN00459383 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: June 2 and 3, 2025 Facility number: 000089 Provider number: 155173 AIM number: 100287760 Census Bed Type: SNF/NF: 57 SNF: 10 Total: 67 Census Payor Type: Medicare: 2 Medicaid: 53 Other: 12 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 10, 2025.	F 0000	June 17, 2025 Indiana Department of Health Division of Long-Term Care, Section 4 B 2 North Meridian Street Indianapolis, Indiana 46204 To Whom it May Concern: A Complaint Survey was conducted at Miller's Merry Manor of Marion on June 3, 2025. Please find the enclosed Plan of Correction being submitted as remedies to the deficiencies that were found during our survey. All systemic changes and education were completed by June 5, 2024. With regards to our Plan of Correction from the June 3, 2025 Complaint Survey we hope that you will find our remedies both sufficient and thoroughly explained in providing a clear picture of how we corrected these concerns. We will continue to abide by our plan of correction as indicated, and will continue to monitor, through audits and correct any future areas of concern per our plan of correction. If you have any questions or require additional information, please contact me at 765 662 3981 Thank you.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	06/17/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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			Sincerely, Paula Juday, HFA, LMSW	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to provide adequate supervision for a cognitively impaired resident to prevent repeated falls for 1 of 3 residents reviewed for accidents. This deficiency resulted in Resident D sustaining multiple fractures to the vertebrae, ribs, and pelvis. Finding includes: During an observation, on 6/2/25 at 9:49 a.m., Resident D lay on his back in his low bed with his eyes closed in his darkened room. A visitor sat in a chair in his room. Resident D's clinical record was reviewed on 6/2/25 at 10:54 a.m. Diagnoses included mild cognitive impairment of uncertain or unknown etiology, unspecified dementia, urinary tract infection, site not specified, bacteriuria, retention of urine, unspecified, and benign prostatic hyperplasia (enlarged prostate) (BPH). Current orders included low bed with floor mat, keep bed in lowest position when in bed every shift (3/22/25), donepezil (for dementia) 5 milligrams (mg) daily at bedtime(3/19/25), sertraline (antidepressant) 25 mg two times a day (4/2/25), tamsulosin (for urinary retention) 0.4 mg two times a day (3/31/25), and oxycodone 5 mg every 6 hours for pain (5/30/25). An admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated the resident	F 0689	**F689 Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D has had no falls since 5/9/2025. Resident D's care plan was updated with interventions following each fall as well as CNA assignment sheet following each fall. Nursing Staff were educated on 6/3/2025 regarding CNA assignment sheets including information communicated on those sheet such as fall interventions. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents residing in the facility have the potential to be affected by the alleged deficient practice ·An audit of all residents with falls from 5/5/2025 – 6/4/2025 was completed by the Director of Nursing by 6/5/2025 ensuring that all residents have appropriate	06/05/2025

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	was severely cognitively impaired. He required setup/clean up assistance with eating. He required supervision/touching staff assistance with oral hygiene. He required partial/moderate staff assistance with personal hygiene, rolling left and right in bed, transfers, and ambulation for 10 feet. He required substantial/maximal staff assistance with toileting hygiene, showering/bathing, and upper/lower body dressing. He had an indwelling catheter and was occasionally incontinent of bowels. He had two falls with no injury since admission. A Nursing-Occurrence Initial Assessment, dated 3/18/25 at 10:50 p.m., indicated the resident fell in his bathroom. The staff observed the resident attempting to get out of bed unassisted, attempted to intervene, and had to lower the resident to the floor. The new immediate intervention was to remind the resident to use the call light. A Facility- Post Occurrence IDT (interdisciplinary team) & fall risk assessment, dated 3/20/25 at 1:01 p.m., indicated the root cause for the fall on 3/18/25 was the new environment, confusion with his BPH and urinary retention. He had recently received intravenous antibiotic for bacteriuria that was discontinued prior to admission to the facility. The IDT recommendations included the physician increased the tamsulosin and ordered labs. A care plan intervention initiated on 3/19/25 indicated labs were ordered. A Nursing-Occurrence Initial Assessment, on 3/22/25 at 6:15 a.m. indicated the resident fell in his room. He was found laying on his back on the floor next to the recliner. The resident indicated he		interventions in place including any needs for additional supervision if needed and is communicated via CNA assignment sheet. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All nursing staff educated on or before 6/5/2025 on the “Fall Management” policy and procedure (Attachment A). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting overseen by the Executive Director ·The QA tool “Fall/Accidents Review” (ATTACHMENT B) that will be utilized 5x week x 4 weeks, monthly x3 months, and quarterly thereafter. This will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting. The facility will do so to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60days thereafter as part of the QA program using the QA tool	

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	did not know how to get a hold of anybody for help. The immediate new intervention was non-skid socks and initiation of 15-minute checks. A Facility-Post Occurrence IDT & fall risk assessment, on 3/24/25 at 8:37 a.m., for the 3/22/25 fall indicated the nursing staff found the resident on the floor on his back next to the recliner. He attempted to self-transfer and fell. The root cause for the fall was the resident's dementia/cognitive impairment. He was being treated for urinary tract infection and had increased confusion. The IDT recommendations included non-skid socks on at bedtime and bed to be in the lowest position with a low-profile mat at bedside. Care plan interventions initiated on 3/22/25 included bed in the lowest position and low profile mat on the floor next to the bed. A Nursing-Occurrence Initial Assessment, on 4/5/25 at 6:15 a.m., indicated the resident was found on the floor in his room sitting on his fall mat with a urinal in his hand. He indicated he wanted to move to the bathroom on his own. The immediate new intervention was initiation of 15-minute checks. A Facility- Post Occurrence IDT & fall risk assessment, on 4/7/25 at 9:58 a.m., for the fall on 4/5/25 at 6:15 a.m., indicated the resident was found on the mat beside his bed, and it was unclear if he fell or sat down on the mat. The root cause was determined to be he had his urinary catheter discontinued on 4/3/25. He continued to have urinary urges. The IDT recommendations included tamsulosin was decreased on 3/31/25 and staff was to toilet resident and assist him to the sit in the recliner in the morning with his urinal within reach.		"Fall/Accident Review" (ATTACHMENT B) specifically monitoring care plan accuracy and revision.	

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A care plan intervention initiated on 4/7/25 and resolved on 5/29/25 included staff to toilet and sit resident in recliner in the morning as he allowed.

A Nursing-Occurrence Initial Assessment, on 4/12/25 at 7:40 a.m., indicated the resident had a fall with injury. He was found on the floor of his room. He indicated he was trying to go to the bathroom. He did not hit his head, but fell on his back and hand. He had two abrasions to his fight finger and bruising to his mid back area. The immediate new intervention was initiation of 15-minute checks.

A Facility- Post Occurrence IDT & fall risk assessment, on 4/14/25 at 2:35 p.m., for the fall on 4/12/25 at 7:40 a.m., indicated the resident fell and received two abrasions to his right finger and bruising to his mid-back. The root cause of the fall was the resident attempted to self-transfer to go to the bathroom. The IDT recommendations included staff to assist resident with toileting every two hours while he was awake.

A care plan intervention initiated on 4/12/25 indicated assist with toileting every two hours.

A Nursing-Occurrence Initial Assessment, on 4/18/25 at 2:15 a.m., indicated the resident was found lying on his right side on the floor in the entrance of his bathroom. He indicated his legs became weak and gave out. The resident's call light was not working at that time. The call light was unplugged, then plugged back in and worked. The immediate new intervention was initiation of 15-minute checks.

A Facility- Post Occurrence IDT & fall risk assessment, on 4/18/25 at 10:37 a.m., for the fall on

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	4/18/25 at 2:15 a.m., indicated the resident attempted to ambulate per self to the bathroom and fell. The root cause of the fall was the resident appeared to have lost his balance and lacked safety awareness to call the staff for assistance. The IDT recommendations included an occupational therapy assessment to determine if the resident needed services to continue due to his decrease in balance and safety with continue falls. The call light was assessed by maintenance. A care plan intervention initiated on 4/18/25 and resolved on 5/29/25 indicated therapy was to determine the need for continued services. A Nursing-Occurrence Initial Assessment, on 4/21/25 at 8:00 p.m., indicated the resident attempted to take himself off the toilet and was found lying on his left side with his head and shoulder against the bathroom door frame. The immediate new intervention was initiation of 15-minute checks. A Facility- Post Occurrence IDT & fall risk assessment, on 4/22/25 at 8:26 a.m., for the fall on 4/21/25 at 8:00 p.m., indicated the resident attempted to self-transfer off the toilet and fell. The root cause of the fall was the resident had dementia/cognitive impairment and poor safety awareness. The IDT recommendations included the staff to assist the resident to the bathroom and not leave him unattended while using the bathroom. A care plan intervention initiated on 4/22/25 indicated staff was to stay with the resident when toileted. A Nursing-Occurrence Initial Assessment, on 5/3/25 at 8:15 p.m., the resident was found laying			

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	on mat beside bed with his head toward the dresser. His feet were extended outwards toward the wall. He indicated he was trying to go to bed and forgot he needed help. The immediate new intervention was initiation of 15-minute checks. A Facility- Post Occurrence IDT & fall risk assessment, on 5/5/25 at 8:41 a.m., for the fall on 5/3/25 at 8:15 p.m., indicated the resident fell when he attempted to go to bed without staff assistance. He forgot to ask for help. The root cause was the resident had dementia/cognitive impairment, poor safety awareness, and attempted to transfer without staff assistance. The IDT recommendations included the staff were to offer to help the resident to lay down after dinner. A care plan intervention initiated on 5/5/25 indicated the resident was to follow up with the in-house ophthalmologist. A Nursing-Occurrence Initial Assessment, on 5/9/25 at 10:30 p.m., indicated the resident had fallen and had no injury. He was found on the floor on his left side. An eINTERACT Change in Condition Evaluation, on 5/10/25 at 6:44 a.m., indicated the resident had a change in condition that started during the night on 5/9/25. He had increased confusion, abrupt change and was unable to perform usual activities, needed more assistance with activities of daily living, general weakness, decline in ambulation/mobility abilities, and a decline in his transferring ability. He had pain in his left hip and symptoms worsened. Movement made the pain worse. Nothing made the pain better. The onset of the pain was new. A Progress Note, dated 5/10/25 at 7:35 a.m.,			

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	indicated the resident was sent to the hospital due to left hip pain. A Nursing-Transfer to Hospital assessment, dated 5/10/25 at 7:43 a.m., indicate the resident was transferred to the hospital on 5/10/25 at 7:00 a.m. The reason for transfer was the resident fell at 10:30 p.m. on 5/9/25. He was complaining of severed pain to his left hip and could not move. A Progress Note, dated 5/10/25 at 12:41 p.m., indicated the resident was admitted to the hospital. The results of a Computed Tomography (CT) scan of the abdomen and pelvis, on 5/10/25 at 10:04 p.m., included the following: acute fractures of the number 9 and 10 thoracic vertebrae, acute fracture of the number 4 lumbar vertebra, acute displaced fractures of the left posterior number 10 and 11 ribs, acute mildly displaced fractures of the left upper and lower pubic rami (pelvis), and a small amount of hemorrhage in the pelvis. A hospital discharge summary, dated 5/15/25, indicated the resident had been admitted on 5/10/25 for multiple fractures. The discharge diagnoses included acute pain, debility, decreased strength, endurance, and mobility, hemothorax on left, multiple fractures of the pelvis with stable disruption of the pelvic ring, and rib fracture. A Nursing-MDS supporting documentation assessment, dated 5/21/25 at 10:56 a.m., indicated the resident required partial/moderate staff assistance with eating and oral hygiene. He required substantial/maximal assistance for upper body dressing and rolling left and right in bed. He was dependent on the staff for toileting hygiene, showering/bathing, lower body dressing, and			

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	putting on and taking off footwear. Transfers and ambulation were not attempted due to the resident's medical condition. During an observation, on 6/2/25 at 12:45 p.m., Resident D sat in a recliner with his feet elevated and shaved himself while his resident representative held a mirror. He had a mechanical lift net under him. At the same time, his resident's representative indicated Resident D had been up walking prior to his fall. Since his readmission to the facility, he had been in bed until the last few days. He had experienced increased pain since his fall, but the pain was beginning to lessen. During an observation, on 6/2/25 at 3:18 p.m., the resident rested in a low bed with his eyes closed. His room was darkened. During an interview, on 6/3/25 at 9:35 a.m., CNA 3 indicated the resident was a "busy body" and all over the place before he fell and went to the hospital. She checked on him often. He did not get out of bed anymore since he had returned from the hospital. The CNA did not know where to find what interventions were utilized to prevent the residents from falling, and she needed to ask her nurse. During an interview, on 6/3/25 at 9:40 a.m., LPN 4 indicated she was not on the nursing unit anytime the resident had fallen. He was very confused when he was first admitted to the facility. He was up and down and wandering everywhere. The staff reminded him constantly to call for assistance. He was confused since he returned from the hospital. She was uncertain if he had gotten up or not since his return from the hospital. During an interview, on 6/3/25 at 9:44 a.m., CNA 5			

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	indicated the resident used gripper socks to prevent falls. He had changed rooms so he could more easily see the bathroom and get to it easier. The facility had a list that told the residents' limitations, but she did not know if it included the residents' fall interventions. She knew what the residents' regular behaviors were and would use interventions based on those. During an interview, on 6/3/25 at 9:47 a.m., the ADON indicated the residents' fall interventions were listed in the electronic medical record and could be accessed by the CNAs and the nurses. The CNA sheets were updated when new interventions were added. The new interventions were communicated verbally as well. The resident had a few falls prior to his fall which resulted in fractures and a hospital stay. During an interview, on 6/3/25 at 11:34 a.m., CNA 7 indicated she had worked at the facility for quite some time and knew what the residents needed. She communicated those needs to new staff that came on the unit. She was uncertain if the fall interventions were listed on the CNA sheet. Safety check lists with 15-minute checks, provided by the DON on 6/3/25 at 11:01 a.m., were reviewed. One safety checklist began on 3/18/25 at 10:45 p.m. and ended on 3/20/25 at 2:00 p.m. (a total of 39.25 hours). Another safety checklist began on 4/18/25 at 2:15 a.m. and ended on 4/19/25 at 6:45 a.m. (a total of 28.5 hours). One more safety checklist began on 4/21/25 at 8:00 p.m. and ended on 4/23/25 at 7:00 p.m. (a total of 47 hours). During an interview, on 6/3/25 at 12:17 p.m., RN 8 indicated the 15-minute checks done after a fall were done for 9 shifts like the neurological checks were done.			

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	During an interview, on 6/3/25 at 12:24 p.m., LPN 9 indicated the 15-minute checks done after a fall were done for 72 hours. During an interview, on 6/3/25 at 12:51 p.m., the DON indicated the resident fell a lot. His catheter had been removed, and he still seemed to have some urinary retention. He continued to try to get up and go to the bathroom. Since he came back from the hospital, he no longer tried to get up. She thought he had multiple falls prior to coming to the facility but was uncertain. When residents who had a history of falling were toileted, she did not expect the staff to leave them in the bathroom unattended. She worked the night shift after the resident fell. He had slept through the night when he woke up he was in severe pain and was unable to move. A current facility policy, provided by the Administrator on 6/3/25 at 1:13 p.m., titled "Fall Management Procedure," indicated the following: " ...To assess all resident for risk factors that may contribute to falling and to provide planned interventions to help prevent falls as identified by the team and based upon root cause analysis to prevent reoccurrence ...." This citation relates to Complaint IN00459383. 3.1-45(a)(2)			