STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING -- B. WING	05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/31/22 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Emergency Preparedness survey, Miller's Merry Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 110 certified beds. At the time of the survey, the census was 36. Quality Review completed on 06/01/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/31/2022 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with	K 0000		

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

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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	Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. A later one story addition, consisting of the east wing constructed prior to March 2003, determined to be Type V (111) was also fully sprinklered, therefore it was surveyed as one building in accordance with LSC Chapter 19. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. Battery powered smoke detectors are installed in all resident rooms. The building is partially protected by a 230 kW diesel powered emergency generator. The facility has the capacity for 110 and had a census of 36 at the time of this survey. Quality Review completed on 06/01/22			
K 0100 SS=D Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms	K 0100	**K100** It is the policy of Miller's Merry	06/30/2022

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	was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect laundry staff. Findings include: Based on observation on 05/31/22 during a tour of the facility from 1:50 p.m. to 3:03 p.m. with the Maintenance Supervisor, the clean air intake in the room behind the dryers in the laundry area was substantially covered with dryer lint. Based on interview at the time of observation, the Maintenance Supervisor agreed there was a substantial amount of dryer lint on the clean air intake behind the dryers and would have the area cleaned. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		Hobart that the facility ensures the laundry area is free from lent and debris to minimize the possibility of a fire emergency requiring evacuation of occupants. All residents and staff have the potential to be affected by this deficient practice. To correct the deficient practice on 6/3/22, the Maintenance Director has cleaned the laundry area and swept the dryer closet to remove all lent and debris to prevent the possibility of a fire emergency. Additionally, the Maintenance Director or Designee will complete the Laundry Room inspection audit weekly for 4 weeks and then monthly thereafter to monitor for compliance (Attachment A). **This information will also be reviewed monthly in the facility's QAA/QAPI Committee monthly (for 3-4 months), and then quarterly thereafter to monitor and ensure continued compliance**. All systematic changes will be completed by June 30th, 2022.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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	Based on observation and interview, the facility failed to replace 2 of 75 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 101 and 153. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility on 05/31/2022 from 1:50 p.m. to 3:03 p.m., manufacturer's documentation affixed to the battery operated smoke alarm installed on the ceiling in resident sleeping Room 153 & 101 indicated the devices were manufactured 09/30/2011. Based on interview at the time of each observation, the Maintenance Supervisor agreed the smoke alarms were more than ten years old. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0300	**K300** It is the policy of Miller's Merry Hobart that the facility has properly functioning battery-operated smoke alarms installed in resident sleeping rooms. All residents and staff have the potential to be affected by this deficient practice. To correct the deficient practice the Maintenance Director purchased and installed new battery-operated smoke detectors on 6/3/2022(Attachment B) in rooms 101,153 and throughout the facility. Additionally, the Maintenance Director or Designee will complete monthly the battery-operated smoke detector inspection in our maintenance system (Attachment C, C1). **This information will also be reviewed monthly in the facility's QAA/QAPI Committee monthly (for 3-4 months), and then quarterly thereafter to monitor and ensure continued compliance.** All systematic changes will be completed by June 30th, 2022.	06/30/2022
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 6 residents and staff in the vicinity of the furnace closet in therapy and kitchen dish area. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:50 p.m. to 3:03 p.m. on 05/31/22, an approximate 8" by 2" space surrounding metal conduit from a breaker box running up through the drop ceiling in a closet housing an HVAC unit in therapy was not firestopped. Additionally, a 1" diameter hole was observed in a lay in ceiling tile in the dish are of	K 0353	**K353** It is the policy of Miller's Merry Manor Hobart to ensure that the facility maintains the ceiling construction throughout the facility that is free from significant irregularities, lumps or indentations and the spare sprinkler box only contains the correct amount of sprinkler heads permitted in the sprinkler box. All residents and staff have the potential to be affected by this deficient practice. To correct the deficient practice on 6/3/22 the Maintenance Director installed a new ceiling tile and fire caulking to cover the opening over the breaker panel. Also, on 6/3/22 the Maintenance Director sealed the 1" diameter hole in the ceiling tile in the dish area of the kitchen with fire caulking. On 6/5/22 the Maintenance Director removed any damaged or obsolete sprinkler head from the sprinkler box and it	06/30/2022

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	the kitchen, exposing the space above. The approximate dimensions were confirmed by the Maintenance Supervisor. These conditions could delay the activation of the sprinklers installed in the ceiling. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the ceiling penetrations and stated they would be properly firestopped. 2. Based on observation and interview, the facility failed to properly store spare sprinklers in accordance with NFPA 101 - 2012 edition, Sections 19.3.5, 9.7 and NFPA 25 - 2010 edition, Sections 5.1.1, 5.2.1, and 5.4.1. This deficient practices could affect all of the residents and staff. Findings include: Based on observations with the Maintenance Supervisor on 05/31/22 at 2:45 p.m., the spare sprinkler box mounted at the sprinkler riser revealed 14 spare sprinklers with 7 spare sprinklers stored loose and not secured in holders in the sprinkler cabinet. Based on interview at the time of observation, the Maintenance Supervisor agreed 7 spare sprinklers were either lying flat or standing upright loose in the cabinet. These findings were reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		now holds the correct amount of sprinkler heads allowed (Attachment D). **This information will also be reviewed monthly in the facility's QAA/QAPI Committee monthly (for 3-4 months), and then quarterly thereafter to monitor and ensure continued compliance.** All systematic changes will be completed by June 30th, 2022.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's			

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	specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 2 of 7 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect over 12 residents, staff and visitors on the east wing. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:50 p.m. to 3:03 p.m. on 05/31/22, resident sleeping rooms and support offices 111 through 119 and 122 through 136 were using the egress corridor as a portion of a return air system. Based on interview at the time of the observations, the Maintenance Supervisor stated an operable HVAC unit supplies HVAC air to each room and each room is not equipped with an air return. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0521	**K521** The facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K521. We have applied for a continuing waiver for financial hardship. Please see attached documentation (Attachment E, E1,E2).	06/30/2022