

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155774	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 MICHIGAN AVE LOGANSPORT, IN 46947
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: March 26, 27, 28, April 1, 2, 2013</p> <p>Facility number: 012036 Provider number: 155774 AIM number: N/A</p> <p>Survey team: Rita Mullen RN TC Bobbi Messman RN</p> <p>Census Bed Type: SNF: 11 Total: 11</p> <p>Census Payer Type: Medicare: 9 Other: 2 Total: 11</p> <p>Miller's Merry Manor was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the recertification and state licensure survey.</p> <p>Quality Review completed on April 9, 2013, by Brenda Meredith, R.N.</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.