STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155589	A. BUILDING -- B. WING	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	730 SCHOOL ST CULVER, IN 46511

(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: 01/09/25 Facility Number: 000489 Provider Number: 155589 AIM Number: 100291210 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 66 certified beds. At the time of the survey, the census was 50. Quality Review completed on 01/13/25.	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: 01/09/25 Facility Number: 000489 Provider Number: 155589 AIM Number: 100291210 At this Life Safety Code survey, Miller's Merry Manor was found in not compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Craig Clemons	Administrator	01/24/2025

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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	Requirements for Participation in Medicare/Medicaid, 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) and 410 IAC 16.2. The original building consisted of the Victory Court, Serenity Court, Grand Court, and common areas. In 2015, a Therapy area and Dining Hall extension were added to the original building. The facility was surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas opened to the corridors, and battery-operated smoke detectors in the resident sleeping rooms. The building is fully protected by a 200-kW diesel-powered generator. The facility has a capacity of 66 beds dually certified for Medicare and Medicaid, with a census of 50 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/13/25.			
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 door to the public men's restroom was provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more	K 0200	Facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or	01/24/2025

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	than one releasing operation. This deficient practice could affect residents or staff in the business office. Findings include: Based on observations made during a tour of the facility with Maintenance Director on 01/09/24 at 1:05 p.m., the public men's restroom door was equipped with an independent dead bolt in addition to a push button code locked door set. Based on interview at the time of observation, the Maintenance Director acknowledged the restroom door as having an independent dead bolt as well as a push button code locked door set latching mechanism on the door. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 01/09/25. 3.1-19(b)		agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. 1. Maintenance director removed the independent deadbolt located on the inside of the men's restroom door. 2. 2. Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3333. Maintenance director /designee will fill out the LSC audit tool for all facility public bathrooms weekly for 4 weeks and then monthly or until compliance is maintained for 60 days. Any findings will be corrected upon discover and documented on the QAPI log. The QAPI tracking logs are reviewed monthly by the QAPI committee to ensure ongoing compliance is no less than 95%. . All systematic changes will be completed by 1/24/2025	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment	K 0324	Facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of	01/24/2025

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	was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 2 residents 5 staff and 2 visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/09/25 at 1:40 p.m., the four (4) burner flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview at the time of the observation, the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or		compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Maintenance director installed physical marker (tape) on kitchen floor to indicate correct placement of 4 burner flat grill. 2. Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3. Maintenance director/designee will fill out the LSC audit tool weekly to ensure physical marker on flooring remains intact and in good condition for 4 weeks and then monthly or until compliance is maintained for 60 days. Any findings will be corrected upon discovery and documented on the QAPI log. The QAPI tacking logs are reviewed monthly by the QAPI committee to ensure ongoing compliance is no less than 95% All systematic changes will be completed by 1/24/2025 ="" aany="" findings="" will="" be="" corrected="" upon="" discovery="" and="" documented="" on="" the="" qapi="" log. ="" tracking=""	

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	cleaning and that he would figure out a way to ensure the stove was returned to an approved design location as soon as possible. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 01/09/25. 3.1-19(b)		logs="" are="" reviewed="" monthly="" by="" committee="" to="" ensure="" ongoing="" compliance="" is="" no="" less="" 95%. <="" p="">	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 01/09/24 at 1:07 p.m. with the Maintenance Director, the Victory Court Hall set of smoke barrier doors had a four-inch gap along the center where the doors came together in the closed position. This was verified by the Maintenance Director at the time of observation who stated that he had been working on the door, and it needed to have the hinges tightened adding that he would complete the repairs as soon as possible. This item was discussed at the exit conference with the Maintenance Director and the facility	K 0374	1. Facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Maintenance director tightened hinges on smoke door and ensured that smoke door closed properly as designed. 2. Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3. Maintenace director/designee will fill out LSC audit toof for all facility smoke doors weekly for 4 weeks then monthly or until	01/24/2025

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	Administrator on 01/09/25. 3.1-19(b)		compliance is maintained for 60 days. Any findings will be corrected upon discoverand documented on the QAPI log. The QAPI tracking logs are reviewed monthly by the QAPI committe to ensure ongoing compliance is no less than 95% All systematic changes will be completed by 1/24/2025 3.	