STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING -- B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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: 03/13/23 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 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 127 certified beds. At the time of the survey, the census was 86. Quality Review completed on 03/20/23	E 0000	Please accept our enclosed plan of correction as credible allegation of compliance for the deficiencies cited curing our annual life safety code survey conducted on March 13th, 2023 at Miller's Merry Manor in Logansport, IN. I hope you will find our remedies corrected the deficiencies cited. We respectfully would like to request paper compliance for all tags cited. Feel free to contact me with any questions or concerns. adm019@millershealthsystems.com Sincerely, Lily Price, HFA Administrator	
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: 03/13/23 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with	K 0000	Please accept our enclosed plan of correction as credible allegation of compliance for the deficiencies cited curing our annual life safety code survey conducted on March 13th, 2023 at Miller's Merry Manor in Logansport, IN. I hope you will find our remedies corrected the deficiencies cited. We respectfully would like to request paper compliance for all tags cited. Feel free to contact me with any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
lily price	administrator	04/05/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	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), Chapter 19, Existing Health Care Occupancies for the main building. This three-story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 127 and had a census of 86 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 03/20/23		questions or concerns. adm019@millershealthsystems.com Sincerely, Lily Price, HFA Administrator	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets located within a horizontal exit was arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic- closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely	K 0226	It is the policy of Miller's Merry Manor that all horizontal exits fully close and latch. 1. The fire doors identified to not have latched properly were immediately inspected and the problem was corrected.	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect as many as 18 residents, 4 staff and 1 visitor. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/13/23 at 2:05 p.m., the fire door set nearest to the first-floor nurses' station failed to fully close and latch into the frame leaving an eight-inch gap when tested on three separate instances. Based on interview at the time of observation, the Maintenance Director confirmed this fire door set nearest to the first-floor nurses' station was a horizontal exit, that it did not fully close or latch into the doorframe, and the aforementioned measurement. This finding was reviewed with the Administrator at the exit conference on 03/13/23 at 3:10 p.m. 3.1-19(b)		2. All residents have the potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur, all maintenance staff will be in-serviced on the policy titled, Fire Door Inspection, Attachment A. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Life Safety 3-13-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 4/10/23.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 main entry overhang in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect as many as 6 residents, 2 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Assistant on 03/13/23 at 1:21 p.m., there was an escutcheon in the main entry overhang that was pushed up into the attic space of the overhang leaving a gap of approximately one inch. Based on interview at the	K 0351	It is the policy of Miller's Merry Manor that escutcheons will cover annular space. 1. The escutcheon identified to not be covering annular space was immediately fixed. 2. All residents have the potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur, all maintenance staff will be educated on the importance of routine inspection of sprinkler heads to check for missing, damaged or misaligned sprinkler head	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	time of observation, the Maintenance Assistant confirmed the one-inch gap and stated that he would have it fixed as soon as he was able to do so. This finding was reviewed with the Administrator at the exit conference on 03/13/23 at 3:10 p.m. 3.1-19(b)		escutcheons. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Life Safety 3-13-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 4/10/23.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher outside resident room #308 were installed in accordance with NFPA 10, Standard for Portable	K 0355	It is the policy of Miller's Merry Manor that all fire extinguishers will be unobstructed and readily accessible.	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice could affect as many as 16 residents, 4 staff and 1 visitor. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/13/23 at 2:39 p.m., the ABC portable fire extinguisher located between resident rooms #308 and #310 was obstructed by a Hoyer lift assist. Based on interview at the time of observation, the Maintenance Director acknowledged the fire extinguisher located between resident rooms #308 and #310 was obstructed and not readily accessible. This finding was reviewed with the Administrator at the exit conference on 03/13/23 at 3:10 p.m. 3.1-19(b)		1. The object blocking the fire extinguisher was immediately moved. 2. All residents have the potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur, all staff will be in-serviced on the importance of fire extinguishers being unobstructed and readily accessible. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Life Safety 3-13-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 4/10/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 M.D.S. office did not use flexible cords or multi-plug adapters as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute	K 0920	It is the policy of Miller's Merry Manor that flexible cords or multi-plug adapters are not used as a substitute for fixed wiring. 1. The multi-plug adapter found was removed immediately. 2. All residents have the	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	for fixed wiring of a structure. This deficient practice could affect as many as 4 residents and 2 staff. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 03/13/23 at 2:32 p.m., a multi-plug adapter was plugged into a wall outlet in the M.D.S. office converting one dual electrical outlet into a quad-electrical outlet. This multi-plug adapter then had a Microwave oven, a Keurig coffee maker, and a small refrigerator plugged into it and not directly into a wall outlet. Based on interview at the time of the observation, the Maintenance Director acknowledged the multi-plug adapter as being used as a substitute for fixed wiring and stated that he would have a discussion with the staff using the office. This finding was reviewed with the Administrator at the exit conference on 03/13/23 at 3:10 p.m. 3.1-19(b)		potential to be affected by the same deficient practice. 3. To ensure that the deficient practice does not recur, all department heads and maintenance staff will be in-serviced on the policy titled "Electrical Power Strip Policy", attachment C. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete the QA Tool titled Life Safety 3-13-23 POC, Attachment B. This tool will be completed 5 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. 5. All systemic changes will be completed by 4/10/23.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State	K 0000	Please accept our enclosed plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	200 26TH ST LOGANSPORT, IN 46947

(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
	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/13/23 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 At this Life Safety Code survey, Miller's Merry Manor was found in compliance with 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), Chapter 18, New Health Care Occupancies for the Rehabilitation wing. This three-story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 127 and had a census of 86 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 03/20/23		of correction as credible allegation of compliance for the deficiencies cited curing our annual life safety code survey conducted on March 13th, 2023 at Miller's Merry Manor in Logansport, IN. I hope you will find our remedies corrected the deficiencies cited. We respectfully would like to request paper compliance for all tags cited. Feel free to contact me with any questions or concerns. adm019@millershealthsystems.com Sincerely, Lily Price, HFA Administrator	