STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING		COMPLETED		
		155235	B. WING			03/13/2023		
	NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	• ==	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	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.		E 00	E 0000 Please accept our end of correction as credible of compliance for the orited curing our annual code survey conducte 13th, 2023 at Miller's Min Logansport, IN.  I hope you will find our corrected the deficient We respectfully would request paper compliatings cited.  Feel free to contact min questions or concerns adm019@millershealtim		ation cies fety arch lanor lies ed.		
	Quality Review cor	mpleted on 03/20/23			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 0	000	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.			
	Manor was found n	ot in compliance with			Feel free to contact me with a	iny		

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

(X6) DATE

TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 608Y21 Facility ID: 000140 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155235	B. WING		03/13/2023			
	NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG			TAG	DEFICIENCY)	DATE			
	Requirements for Pa	articipation in		questions or concerns.				
		, 42 CFR Subpart 483.90(a),		adm019@millershealthsystem	is.co			
	Life Safety from Fire and the 2012 edition of the			m				
		ction Association (NFPA) 101,						
		LSC), Chapter 19, Existing		Sincerely,				
	Health Care Occupa	ancies for the main building.		Lily Price, HFA				
				Administrator				
	_	ility with a basement was						
		Type II (111) construction and						
		he facility has a fire alarm						
	•	detection in the corridors,						
		corridors, and battery powered						
	smoke detectors in all resident sleeping rooms.							
	-	npacity of 127 and had a						
	census of 86 at the t	time of this visit.						
	All areas where resi	idents have customary access						
		d all areas providing facility						
	_	klered except for one detached						
	garage which was n	-						
	garage which was h	or sprinkiered.						
	Quality Review con	npleted on 03/20/23						
K 0226	NFPA 101							
SS=E	Horizontal Exits							
Bldg. 01	Horizontal Exits							
5 -		used, are in accordance						
		provisions of 18.2.2.5.1						
		7, or 19.2.2.5.1 through						
	19.2.2.5.4.	, <b>g</b>						
	18.2.2.5, 19.2.2.5							
	Based on observation	on and interview, the facility	K 0226	It is the policy of Miller's Merry	04/10/2023			
	failed to ensure 1 of	f 2 fire door sets located within		Manor that all horizontal exits				
	a horizontal exit wa	s arranged to automatically		close and latch.				
	close and latch. LSO	C section 7.2.4.3.10 requires all						
	fire door assemblies	s in horizontal exits shall be		1. The fire doors identified	to			
	self-closing or autor	matic- closing. In addition		not have latched properly were	e			
		lard for Fire Doors and Other		immediately inspected and the	<b>;</b>			
	Opening Protectives	s, section 6.1.4.2.1 states		problem was corrected.				
	self-closing doors shall swing easily and freely							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet Page 2 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	, ,	JILDING	onstruction 01	(X3) DATE : COMPL 03/13/	ETED
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			200 261	ADDRESS, CITY, STATE, ZIP COD TH ST ISPORT, IN 46947			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	and shall be equipped cause the door to clopened. This deficience residents, 4 staff and Findings include:  Based on observation facility with the Mat 2:05 p.m., the first first-floor nurses' stallatch into the frame when tested on three on interview at the Maintenance Direct nearest to the first-fhorizontal exit, that into the doorframe, measurement.  This finding was residents.	ed with a closing device to ose and latch each time it is ent could affect as many as 18 d 1 visitor.  ons made during a tour of the intenance Director on 03/13/23 e door set nearest to the ation failed to fully close and leaving an eight-inch gap e separate instances. Based time of observation, the tor confirmed this fire door set floor nurses' station was a it did not fully close or latch and the aforementioned  viewed with the Administrator ce on 03/13/23 at 3:10 p.m.		TAG	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, Attachm A.  4. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM/Designee will complete to QA Tool titled Life Safety 3-13 POC, Attachment B. This tool be completed 5 times a week weeks, then weekly for 4 weels then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.  5. All systemic changes will completed by 4/10/23.	ent ent he -23 will for 2 ks, d e to e	DATE
SS=E Bldg. 01	Sprinkler System - Spinkler System -						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet

Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/13/2023 155235 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 26TH ST MILLER'S MERRY MANOR LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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) K 0351 04/10/2023 Based on observation and interview, the facility It is the policy of Miller's Merry failed to maintain the ceiling construction in 1 of 1 Manor that escutcheons will cover main entry overhang in accordance with NFPA 13, annular space. Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states The escutcheon identified to plates, escutcheons, or other devices used to not be covering annular space was cover the annular space around a sprinkler shall immediately fixed. be metallic or shall be listed for use around a sprinkler. This deficient practice could affect as All residents have the many as 6 residents, 2 staff, and 2 visitors. potential to be affected by the same deficient practice. Findings include: To ensure that the deficient Based on observations made during a tour of the practice does not recur. all facility with the Maintenance Assistant on maintenance staff will be educated 03/13/23 at 1:21 p.m., there was an escutcheon in on the importance of routine the main entry overhang that was pushed up into inspection of sprinkler heads to the attic space of the overhang leaving a gap of check for missing, damaged or approximately one inch. Based on interview at the misaligned sprinkler head

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet

Page 4 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023				
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	confirmed the one-i would have it fixed so.  This finding was re at the exit conference 3.1-19(b)	the Maintenance Assistant inch gap and stated that he as soon as he was able to do viewed with the Administrator ce on 03/13/23 at 3:10 p.m.			escutcheons.  4. To monitor the corrective actions and ensure the deficie practice will not recur, the ADM/Designee will complete t QA Tool titled Life Safety 3-13 POC, Attachment B. This tool be completed 5 times a week weeks, then weekly for 4 week then monthly for 3 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and had Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.  5. All systemic changes will completed by 4/10/23.	nt he -23 will for 2 ss, d to e			
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of outside resident roo	nguishers guishers are selected, id, and maintained in NFPA 10, Standard for nguishers.	K 0	355	It is the policy of Miller's Merry Manor that all fire extinguisher will be unobstructed and readi accessible.	s	04/10/2023		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ΓED
		155235	B. WING 03/13/2023			023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				200 26			
MILLER'S MERRY MANOR				LOGAN	NSPORT, IN 46947		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE '	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		2010 Edition. Section 1-6.3				_	
	_	shers shall be conspicuously			The object blocking the figure 1.  The object blocking the figure 1.	fire	
	-	will be readily accessible and			extinguisher was immediately		
	_	ole in the event of a fire.			moved.		
		ll be located along normal uding exits from areas. This			O All regidents have the		
		ould affect as many as 16			2. All residents have the		
	residents, 4 staff an	<del>_</del>			potential to be affected by the		
	residents, 4 starr an	u i visitoi.			same deficient practice.		
	Findings include:				3. To ensure that the defici	ent	
					practice does not recur, all sta		
	Based on observation	ons made during a tour of the			will be in-serviced on the		
	facility with the Maintenance Director on 03/13/23				importance of fire extinguished	rs	
	at 2:39 p.m., the AI	BC portable fire extinguisher			being unobstructed and readil		
	located between res	ident rooms #308 and #310			accessible.		
	was obstructed by a	Hoyer lift assist. Based on					
	interview at the tim	e of observation, the			4. To monitor the corrective	9	
		or acknowledged the fire			actions and ensure the deficie	nt	
		d between resident rooms #308			practice will not recur, the		
		ucted and not readily			ADM/Designee will complete t		
	accessible.				QA Tool titled Life Safety 3-13		
					POC, Attachment B. This tool		
		viewed with the Administrator			be completed 5 times a week		
	at the exit conferen	ce on 03/13/23 at 3:10 p.m.			weeks, then weekly for 4 week		
	2.1.10(1-)				then monthly for 3 months, an		
	3.1-19(b)				quarterly thereafter and will be		
					reviewed in one year by the	<sub>to</sub>	
					Quality Assurance (QA) team determine the frequency of the		
					audit. Any concerns will be	7	
					addressed immediately and ha	ave a	
					Quality Assurance and Quality		
					Improvement Action Plan	'	
					completed. The action plan wi	<sub>II be</sub>	
					reviewed at the monthly QAPI		
					meeting with changes made a		
					appropriate.		
					' '		
					5. All systemic changes wi	l be	
					completed by 4/10/23.		

CENTERS FOR	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED			
		155235	B. WING		03/13/2023			
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua	ent - Power Cords and ent - Power Cords and eatient care vicinity are only nts of movable ed electrical equipment les that have been elified personnel and meet						
	the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.30)	0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE of UL 60601-1. Power strips the patient care rooms meet UL 1363. In poms, power strips meet is. All power strips are precautions. Extension is as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was its the conditions of 10.2.4. Poly, 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5						
	Based on observation failed to ensure 1 of flexible cords or musubstitute for fixed electrical wiring and accordance with NF Code. NFPA 70, 20 requires that, unless	on and interview, the facility 1 M.D.S. office did not use 1 liti-plug adapters as a wiring. LSC 9.1.2 requires 1 equipment shall be in 1 Edition, Article 400.8 2 specifically permitted, flexible all 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 use as a substitute for fixed wiring.  1. The multi-plug adapter fo was removed immediately.  2. All residents have the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet

Page 7 of 9

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/13/2023		
	NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
MILLER'S (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR for fixed wiring of a practice could affect staff.  Findings include:  Based on observation facility with the Ma at 2:32 p.m., a multit a wall outlet in the Ma dual electrical outle This multi-plug ada oven, a Keurig coffer frigerator plugged wall outlet. Based o observation, the Ma acknowledged the n used as a substitute that he would have a using the office.  This finding was rev	estatement of Deficiencie CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION In structure. This deficient It as many as 4 residents and 2  The structure of the intenance Director on 03/13/23 In-plug adapter was plugged into M.D.S. office converting one It into a quad-electrical outlet. Interpret then had a Microwave It into it and not directly into a In interview at the time of the intenance Director Inulti-plug adapter as being In for fixed wiring and stated In a discussion with the staff  In the staff In the sta		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  potential to be affected by the same deficient practice.  3. To ensure that the deficie 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-POC, Attachment B. This tool be completed 5 times a week 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 ha Quality Assurance and Quality Improvement Action Plan completed. The action plan will reviewed at the monthly QAPI meeting with changes made as	ent ent ne -23 will for 2 as, d	(X5) COMPLETION DATE	
K 0000					appropriate.  5. All systemic changes will completed by 4/10/23.	be		
Bldg. 02	A Life Safety Code	Recertification and State	K 00	000	Please accept our enclosed pl	an		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

608Y21

Facility ID: 000140

If continuation sheet

Page 8 of 9

OT 1 TO 1	TO OF PERIODE WATER	TATAL DE CAMPER CAMPET YER COLUMN	(12) ) (( 12 mm) = -	ON LOTTING TO A LO	TANK DAME OF DAMES
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED
		155235	B. WING		03/13/2023
		<u> </u>		ADDRESS CITY OF THE STREET	
NAME OF P	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	
			200 26		
MILLER'S	S MERRY MANOR		LOGAN	NSPORT, IN 46947	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1.1.0		vas conducted by the Indiana	1110	of correction as credible alleg	
	I -	lth in accordance with 42 CFR		of compliance for the deficient	
	483.90(a).	itii iii accordance witii 42 Ci K		1	
	403.90(a).			cited curing our annual life sa	-
	C D-4 02/1/	2/22		code survey conducted on Ma	
	Survey Date: 03/13	3/23		13th, 2023 at Miller's Merry M	anor
	F 317 M 1 6	000140		in Logansport, IN.	
	Facility Number: (			I hope you will find our remed	
	Provider Number:			corrected the deficiencies cite	ed.
	AIM Number: 100	266960		We respectfully would like to	
				request paper compliance for	all
	1	Code survey, Miller's Merry		tags cited.	
	Manor was found in	•		Feel free to contact me with a	ny
	Requirements for P	-		questions or concerns.	
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),		adm019@millershealthsysten	ns.co
	Life Safety from Fi	re and the 2012 edition of the		m	
	National Fire Prote	ction Association (NFPA) 101,			
	Life Safety Code (I	LSC), Chapter 18, New Health		Sincerely,	
	Care Occupancies	for the Rehabilitation wing.		Lily Price, HFA	
				Administrator	
	This three-story fac	cility with a basement was			
	1	f Type II (111) construction and			
		The facility has a fire alarm			
	1	detection in the corridors,			
	1 -	corridors, and battery powered			
		all resident sleeping rooms.			
		apacity of 127 and had a			
	census of 86 at the				
	census of 80 at the	time of this visit.			
	All grage where was	idents have customary access			
		nd all areas providing facility			
	_				
		klered except for one detached			
	garage which was r	ioi sprinkierea.			
	0 10 P	1 4 1 02/20/22			
	Quality Review coi	mpleted on 03/20/23			
				1	I

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 608Y21 Facility ID: 000140 If continuation sheet Page 9 of 9