| 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 | 01/09/2023 |

| 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<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 01/09/23<br><br>Facility Number: 000489<br>Provider Number: 155589<br>AIM Number: 100291210<br><br>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<br><br>The facility has 66 certified beds. At the time of the survey, the census was 40.<br><br>Quality Review completed on 01/12/23 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 01/09/23<br><br>Facility Number: 000489<br>Provider Number: 155589<br>AIM Number: 100291210<br><br>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 |
|---|---|---|
| Jason Hill | Administrator | 02/03/2023 |

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.

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| | 155589 | A. BUILDING 01<br>B. WING | 01/09/2023 |

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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.<br><br>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 40 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 01/12/23 | | | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated | | | |

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| | from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 6 hazardous areas, such as a House Keeping / Bio-hazard room or a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 10 residents, 2 staff and 1 visitor.<br><br>Findings include:<br><br>Based on observations made on 01/09/23 at 1:40 p.m. during a tour of the facility with the Maintenance Supervisor, it was noted that | K 0321 | K321<br>It is the policy of Miller's Merry Manor Culver to keep resident rooms free of additional items that would require a self closing door based on the room being used for storage.<br>All residents have the potential to be affected by this practice.<br>The additional mattresses and items were removed from the room.<br>To prevent reoccurrence the Administrator or designee will | 01/27/2023 |

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| | resident room #412 had been converted to a storage area. This room was approximately 120 square feet in size, contained five bed mattresses, a wooden table, a wooden chair with a cloth covered seat, a wooden three drawer chest, and two 18-inch by 18-inch by 42-inch cardboard boxes containing bed mattresses. The aforementioned storage being kept in the room created a hazardous area, but there was no self-closing device on the door leading out to the corridor. Based on an interview at the time of the observation, the Maintenance Supervisor stated that this room was currently being used for facility storage and he was not aware of the necessity for a self-closing device being needed on hazardous rooms that opened to the corridor.<br><br>This finding was reviewed with the Maintenance Supervisor at the exit conference on 01/09/23 at 2:25 p.m. only as the facility Administrator was not available at this time.<br><br>3.1-19(b) | | fill out the LSC audit tool for 12 rooms per week(Attachment A), weekly 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 tracking logs are reviewed monthly by the QAPI committee to ensure ongoing compliance is no less 95%.<br>All systematic changes will be completed by January 27, 2023. | |
| K 0345<br>SS=C<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in | K 0345 | K345<br>It is the policy of Miller's Merry Manor Culver to ensure the | 01/27/2023 |

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| | accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on observation of the fire alarm control panel on 01/09/23 at 1:35 p.m. during a tour of the facility with the Maintenance Supervisor, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 03/03/23 at 19:24 hours. Based on interview at the time of observation, the Maintenance Supervisor indicated he was aware of the date and time discrepancy as his vendor has come out to try and correct the date and time on the panel, but as of yet, they have had no luck in doing so.<br><br>This finding was reviewed with the Maintenance Supervisor at the exit conference on 01/09/23 at 2:25 p.m. only as the facility Administrator was not available at the aforementioned time.<br><br>3.1-19(b) | | fire alarm system is tested and maintained per NFPA guidelines.<br>All residents have the potential to be affected by this practice.<br>A new fire panel has been purchased and will be installed upon arrival. (Attachment 1)<br>To prevent reoccurrence the Administrator or designee will fill out the LSC audit tool, once the new panel is installed(Attachment A), weekly 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 tracking logs are reviewed monthly by the QAPI committee to ensure ongoing compliance is no less 95%.<br>All systematic changes will be completed by 3/15/23. | |