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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	IA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/26/2024		
	ROVIDER OR SUPPLIER		<u>,                                      </u>	1651 N	ADDRESS, CITY, STATE, ZIP COD CAMPBELL ST IAPOLIS, IN 46218	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
E 0004 SS=F Bldg	conducted by the In accordance with 42  Survey Date: 06/26  Facility Number: 0 Provider Number: 1002  At this Emergency I Merry Manor was for Emergency Prepare Medicare and Medicand Suppliers, 42 C  The facility has 114 the survey, the cens  Quality Review conductive with the survey of the surve	00500 155557 266220 Preparedness survey, Miller's cound not in compliance with dness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of us was 53. mpleted on 06/28/24 4(a), 418.113(a), 5(a), 483.475(a), 485.68(a), 20(a), 485.68(a), 20(a), 486.360(a), (a) Review and Update  5.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 5.360(a), §491.12(a), 625(a), 625(a)	E 00	000	Please find the enclosed Plan Correction as the remedies to deficiencies found during our Safety Code Recertification S with Emergency Preparednes Survey conducted on June 26 2024. All areas have been corrected and effective syster and auditing tools are in place prevent reoccurrence.	the Life urvey s s,	
	i Guerai, State and	i local efficigency					

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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: EVV021 Facility ID: 000500 If continuation sheet Page 1 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2024
	PROVIDER OR SUPPLIEF	3	1651 N	ADDRESS, CITY, STATE, ZIP COD I CAMPBELL ST NAPOLIS, IN 46218	
(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)	(X5) COMPLETION DATE
	must develop esta comprehensive er program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness planand updated at leamust do all of the * [For hospitals at §485.625(a):] Emergency Planand updated at leamust do all of the section, utilizing at * [For LTC Facilitie Emergency Planand updated at leamust do all of the section, utilizing at * [For ESRD Facil Emergency Planand updated at leamust develop and main preparedness planand updated at leamus	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach.  es at §483.73(a):]  The LTC facility must itain an emergency in that must be reviewed, ast annually.  ities at §494.62(a):]  The ESRD facility must itain an emergency in that must be [evaluated], ast every 2 years.			
	failed to develop an	view and interview, the facility and maintain an emergency hat was reviewed and updated	E 0004	What corrective action(s) wi be accomplished for those residents found to have bee	

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet Page 2 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2024
	PROVIDER OR SUPPLIEF	2	1651 N	ADDRESS, CITY, STATE, ZIP COD I CAMPBELL ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
	at least annually in 483.73(a). This define occupants.  Findings include:  Based on review of Preparedness Plan of the to 9:37 a.m. with the documentation for a Preparedness Plan of the most recent two available for review had not been review months with a last of as 09/23/21. Based record review, the Market facility has not preparedness programmers.	accordance with 42 CFR icient practice could affect all with facility's Emergency on 06/26/24 between 9:12 a.m. in updated Emergency reviewed by the facility within live-month period was not with the past twelve documented review date listed on interview at the time of Maintenance Supervisor agreed thad its entire emergency am reviewed by the facility in the Emergency in the Emergency		affected by the deficient practice; The Emergency Prepared plan was reviewed on 5/3 signature sheet. This she available at the time of sit the incorrect sheet from 5 was given to surveyor in (Attachment A).  Maintenance educated of of updated documents.  How other residents have potential to be affected same deficient practice identified and what correction(s) will be taken; All residents residing in the had the potential to be affected this alleged deficient practice. The Emergency Prepared plan was reviewed on 5/3 signature sheet. This she available at the time of sit the incorrect sheet from 5 was given to surveyor in Maintenance educated of location of updated documents. What measures will be place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and mainted director re-educated on Emergency Preparedness on or before 7/8/24 (Attaction of the corrective action will be monitored to ensure that the corrective action will be monitored to ensure the corrective action will be monitored to ensure deficient practice will not	dness 15/24 per eet was urvey but 0/23/21 error  In location  ving the by the will be ective  In efacility fected by ctice. Idness 15/24 per eet was urvey but 0/23/21 error. In ments. In

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet

Page 3 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	r í	UILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2024	
	PROVIDER OR SUPPLIER			1651 N	ADDRESS, CITY, STATE, ZIP COD CAMPBELL ST IAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0013 SS=F Bldg	484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and pr develop and imple preparedness poli on the emergency (a) of this section,	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 9.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 9.360(b), §491.12(b),			recur, i.e., what quality assurance program will be pinto place; Maintenance director or design will use the QA tool titled, "Lift Safety Corrections 2024" 3x weekly for 4 weeks, 2 time were for 2 weeks then monthly thereafter as part of the facility QAPI Program. Any concernst identified will be corrected upon discovery and findings documented on quality assuration. All QA tools and findings be reviewed monthly in the factory in the factory months until the facility maintages. (Attachment C)	nee eekly y on ance will cility oing 6	

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 4 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	 UILDING	NSTRUCTION	(X3) DATE COMPL 06/26	ETED
	PROVIDER OR SUPPLIER S MERRY MANOR		1651 N	DDRESS, CITY, STATE, ZIP COD CAMPBELL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	section. The police	an at paragraph (c) of this sies and procedures must updated at least every 2				
	and procedures. I develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policy be reviewed and united to the communication of th	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.				
	*[For PACE at §46 procedures. The develop and imple preparedness police on the emergency (a) of this section, paragraph (a)(1) communication placetion. The police address manager nonmedical emerglimited to: Fire; equal failure; care-related disasters likely to safety of the partice.	60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be atted at least every 2 years.				
		ties at §494.62(b):] Policies The dialysis facility must ement emergency				

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 5 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	1	COMPLETED	
		155557	B. W	NG	_	06/26	/2024	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
		<b>L</b>			CAMPBELL ST			
MILLER'S	S MERRY MANOR			INDIAN	IAPOLIS, IN 46218			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		icies and procedures, based						
		plan set forth in paragraph risk assessment at						
	' '							
	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this							
	section. The policies and procedures must							
	be reviewed and updated at least every 2							
	years. These emergencies include, but are							
	not limited to, fire, equipment or power							
	failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic							
	area.	, , , , ,						
	Based on record review and interview, the facility		E 0	013	What corrective action(s) wil	I	07/08/2024	
	failed to develop an	id implement emergency			be accomplished for those			
	preparedness polici	es and procedures. The			residents found to have been	1		
	policies and proced	ures must be reviewed and			affected by the deficient			
	updated at least ann	ually in accordance with 42			practice;			
	CFR 483.73(b). Thi	is deficient practice could affect			The Emergency Preparedness	8		
	all residents in the f	facility.			plan including policies and			
					procedures was reviewed on			
	Findings include:				5/15/24 per signature sheet. T	his		
					sheet was available at the time	e of		
		the facility's Emergency			survey but the incorrect sheet	from		
	_	on 06/26/24 between 9:12 a.m.			9/23/21 was given to surveyor	in		
		e Maintenance Supervisor,			error. (Attachment A).			
		updated policies and			Maintenance educated on loca	ation		
		d by the facility within the			of updated documents.			
		month period was not						
		7. The emergency plan provided			How other residents having t			
		ved within the past twelve			potential to be affected by th			
		documented review date listed			same deficient practice will be			
		on interview at the time of			identified and what correctiv	е		
		Maintenance Supervisor agreed			action(s) will be taken;			
	the facility has not had its entire emergency				All residents residing in the fac	-		
		am reviewed by the facility			had the potential to be affected	a by		
		ent twelve-month period based			this alleged deficient practice.			
	on the date written				The Emergency Preparedness	6		
	Preparedness binde	r.			plan including policies and			
	I		1		procedures was reviewed on		I	

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet Page 6 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2024
	ROVIDER OR SUPPLIER		1651 N	ADDRESS, CITY, STATE, ZIP COD N CAMPBELL ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETION DATE
				5/15/24 per signature sheet. sheet was available at the tir survey but the incorrect sheet 9/23/21 was given to survey error.  Maintenance educated on loof updated documents.  What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur;  Administrator & maintenance director re-educated on Emergency Preparedness P and Procedures review on o before 7/8/24 (Attachment B How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place;  Maintenance director or des will use the QA tool titled, "L Safety Corrections 2024" 3x weekly for 4 weeks, 2 time w for 2 weeks then monthly thereafter as part of the facil QAPI Program. Any concernidentified will be corrected updiscovery and findings documented on quality assurance for a minimum of months until the facility main 95% compliance for 60days. (Attachment C)	me of et from or in ocation into  into  e olicies r ). s) the the  put  ignee ife  veekly  ity  is pon  rance s will acility joing f 6 ttains

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet

Page 7 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING COMPL					
		155557	B. WING	·		06/26	/2024
	PROVIDER OR SUPPLIER		1	1651 N	DDRESS, CITY, STATE, ZIP COD CAMPBELL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
E 0029 \$\$ = F Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §485.68(c), §485.6: §485.920(c), §486: §494.62(c).  (c) The [facility] mean emergency preplan that complies local laws and muat least every 2 years facilities]. Based on record reversible facilities and muat least every 2 years facilities. Based on record reversible facilities and muat least every 2 years facilities. Based on record reversible facilities and muat least every 2 years facilities. Based on record reversible facilities and muat least every 2 years facilities. Based on record reversible facilities and preparedness community facilities. Findings include:  Based on review of Preparedness Plan of the second s	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 2.55(c), §485.727(c), 2.360(c), §491.12(c), 2.360(c), §491.12(c), 2.360(c), §491.12(c), 2.360(c), 2.360(c	E 0029	9	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Emergency Preparedness plan including communication plan was reviewed on 5/15/24 signature sheet. This sheet wa available at the time of survey the incorrect sheet from 9/23/24 was given to surveyor in error (Attachment A). Maintenance educated on local of updated documents.  How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	n s 4 per as but 21 . ation the	07/08/2024

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 8 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COM			COMPL	ETED
		155557	B. W	ING		06/26	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			CAMPBELL ST		
MILLER'S	S MERRY MANOR		INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		by the facility within the most			All residents residing in the fac	•	
		h period based on the date			had the potential to be affected	d by	
	written in the Emer	gency Preparedness binder.			this alleged deficient practice.		
					The Emergency Preparedness		
					plan including communication		
					plan was reviewed on 5/15/24	-	
					signature sheet. This sheet wa		
					available at the time of survey		
					the incorrect sheet from 9/23/2		
					was given to surveyor in error.		
					Maintenance educated on		
					location of updated documents	5.	
					What measures will be put in	ito	
					place and what systemic		
			1		changes will be made to		
					ensure that the deficient		
					practice does not recur;		
					Administrator & maintenance		
					director re-educated on		
					Emergency Communication pl	an	
					review on or before 7/8/24		
					(Attachment B).		
			1		How the corrective action(s)		
					will be monitored to ensure t	he	
			1		deficient practice will not		
					recur, i.e., what quality	4	
					assurance program will be p	ut	
					into place;		
					Maintenance director or design		
					will use the QA tool titled, "Life	;	
					Safety Corrections 2024" 3x	okly	
					weekly for 4 weeks, 2 time we	ckiy	
					for 2 weeks then monthly thereafter as part of the facility	,	
					QAPI Program. Any concerns		
					identified will be corrected upo		
					discovery and findings	711	
			1		documented on quality assura	nce	
			1		log All OA tools and findings		

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 9 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155557	A. BUILDING B. WING		COMP	E SURVEY PLETED 5/2024
	PROVIDER OR SUPPLIER S MERRY MANOR		1651 N	ADDRESS, CITY, STATE, ZIP CO CAMPBELL ST IAPOLIS, IN 46218	νD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
				be reviewed monthly in QAPI meeting to ensure compliance for a minimum onths until the facility 95% compliance for 600 (Attachment C)	e ongoing um of 6 maintains	
E 0036 SS=F Bldg	484.102(d), 485.6: 485.727(d), 485.9: 491.12(d), 494.62(d) EP Training and T §403.748(d), §416(g), §441.184(d), §460(g), §485.68(d), §485.920(d), §485.920(d), §486.9494.62(d).  *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625(g), 485.727, CMHCs at §486.360, and RH Training and testing develop and maintended preparedness training and testing that is based on the in paragraph (a) of assessment at paragraph (b) of this section, policies at (b) of this section, plan at paragraph training and testing reviewed and updates.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting 5.54(d), §418.113(d), 1.84(d), §482.15(d), 475(d), §484.102(d), 525(d), §485.727(d), 1.360(d), §491.12(d), 1.360(d), §491.12(d), 1.360(d),				

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 10 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	(X2) MULTIPI A. BUILDIN B. WING	E CONSTRUCTION  G		(X3) DATE : COMPL 06/26/	ETED
	PROVIDER OR SUPPLIER	<u>.</u>	165	EET ADDRESS, CITY, S 1 N CAMPBELL S IANAPOLIS, IN 46	ST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	X (EACH CORREC CROSS-REFERE	C'S PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	and maintain an e training and testin the emergency pla of this section, risk (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/II requirements for eat §483.470(i).  *[For ESRD Facility Training, testing, and its in the emergency preparance on the emergency (a) of this section, paragraph (a)(1) of procedures at paragraph (a)(1) of procedures at paragraph (a)(1) of this section. The train in the communication of this section. The train in the emergency preparance on the emergency preparance of the section. The train in the communication the communication the communication.	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based replan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and					

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 11 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155557		A. BUII	A. BUILDING CO			B) DATE SURVEY COMPLETED 06/26/2024	
	PROVIDER OR SUPPLIER			1651 N	DDRESS, CITY, STATE, ZIP COD CAMPBELL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on record reversal failed to develop and preparedness testing was reviewed and used accordance with 42 practice could affect.  Based on review of Preparedness Plane to 9:37 a.m. with the documentation for a program reviewed by recent twelve-montion review. The emergence been reviewed with a last documented related by the Maintenance Sur has not had its entire program reviewed by recent twelve-montions.	riew and interview, the facility d maintain an emergency g and training program that pdated at least annually in CFR 483.73(d). This deficient	E 003		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  The Emergency Preparedness plan including testing and train was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey the incorrect sheet from 9/23/2 was given to surveyor in error. (Attachment A).  Maintenance educated on local of updated documents.  How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;  All residents residing in the fact had the potential to be affected this alleged deficient practice. The Emergency Preparedness plan including testing and train was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey the incorrect sheet from 9/23/2 was given to surveyor in error. Maintenance educated on local of updated documents.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator & maintenance director re-educated on Emergency Preparedness testing the surveyor prepared	n s ning s but 21	07/08/2024

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 12 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155557			A. BUILDING  B. WING	INSTRUCTION	COMPLETED 06/26/2024
	ROVIDER OR SUPPLIER		1651 N	ADDRESS, CITY, STATE, ZIP COD CAMPBELL ST APOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				and training review on or befor 7/8/24 (Attachment B).  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place;  Maintenance director or design will use the QA tool titled, "Life Safety Corrections 2024" 3x weekly for 4 weeks, 2 time were for 2 weeks then monthly thereafter as part of the facility QAPI Program. Any concernsidentified will be corrected upon discovery and findings documented on quality assuration. All QA tools and findings where the entire to ensure ongoing compliance for a minimum of 6 months until the facility mainta 95% compliance for 60days. (Attachment C)	he  ut  nee ekly  on nce will bility ing 6
K 0000					
Bldg. 01	Licensure Survey w	00500 155557	K 0000	Please find the enclosed Plan Correction as the remedies to deficiencies found during our L Safety Code Recertification Su with Emergency Preparedness Survey conducted on June 26 2024. All areas have been corrected and effective system and auditing tools are in place prevent reoccurrence.	the Life urvey s

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 13 of 21

NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR  MILLER'S MERRY MANOR  SIMMARY STATEMENT OF DEFICIENCE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  At this Life Safety Ode Survey, Miller's Merry  Manor was found not 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 19, Existing  Health Care Occupancies and 410 IAC 16.2.  This facility, with a two-story center section and liwo one story wings, was determined to be of  Type V (111) construction and fully sprinklered.  The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated  smoke detectors in all 60 resident sleeping rooms.  The facility has a capacity of 114 and had a census of 57 at the time of this visit.  All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.  Quality Review completed on 06/28/24  NFPA 101  Means of Egress - General  Alses, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155557		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/26/2024	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYTING PROMATION  At this Life Safety Code survey, Miller's Merry Manor was found not 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 19, Existing Health Care Occupancies and 410 IAC 16.2.  This facility, with a two-story center section and two one story wings, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all 60 resident sleeping rooms. The facility has a capacity of 114 and had a census of 57 at the time of this visit.  All areas where residents have customary access were sprinklered. The facility has battery operated building providing storage services which was not sprinklered.  Quality Review completed on 06/28/24  K 0211  NFPA 101  SS=E  Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			2	1651 N	I CAMPBELL ST	
At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CPR 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 and 410 IAC 16.2.  This facility, with a two-story center section and two one story wings, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all 60 resident sleeping rooms. The facility has a capacity of 114 and had a census of 57 at the time of this visit.  All areas where residents have customary access were sprinklered. The facility has sone detached building providing storage services which was not sprinklered.  Quality Review completed on 06/28/24  K 0211  NFPA 101  SS=E  Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2					(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
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building providing storage services which was not sprinklered.  Quality Review completed on 06/28/24  K 0211 NFPA 101 SS=E Means of Egress - General Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2						
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Quality Review completed on 06/28/24  K 0211 NFPA 101 SS=E Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			storage services which was			
K 0211 NFPA 101 SS=E Means of Egress - General Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2		not sprinklered.				
SS=E Means of Egress - General Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2		Quality Review cor	mpleted on 06/28/24			
Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2	K 0211	_				
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in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2			-			
of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2		•				
all obstructions to full use in case of emergency, unless modified by 18/19.2.2						
emergency, unless modified by 18/19.2.2		1 -	-			
III/Ougit 10/19.2.11.			_			
18.2.1, 19.2.1, 7.1.10.1		_				
				K 0211	What corrective action(s) will	07/09/2024
Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were  K 0211  What corrective action(s) will be accomplished for those			-	N 0211		0//08/2024
continuously maintained free of all obstructions  residents found to have been			<del>-</del>			

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155557		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/26/2024	
	PROVIDER OR SUPPLIER		1651 N	ADDRESS, CITY, STATE, ZIP COD N CAMPBELL ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR or impediments to f fire or other emerge could affect as many visitors in the facilit Findings include:  Based on the initial from 9:00 a.m. to 9:	walk through of the facility 08 a.m. on 06/26/24, two black	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  affected by the deficient practice; The two black plastic non-who trash cans outside room #243 were immediately removed fro blocking means of egress upon discovery on 6/26/24. How other residents having potential to be affected by the	eeled som on the ne
	corridor immediatel Based on observation Supervisor during a at 12:15 p.m., the two located in the corridary #243. Based on interpretation observation, the Matthe aforementioned continuously maintary or impediments to a of fire or other emergent.  This finding was ag	trash cans were stored in the y outside resident room #243. ons with the Maintenance tour of the facility on 06/26/24 we black trash cans were still for outside of resident room rview at the time of the intenance Supervisor agreed means of egress was not ained free of all obstructions flow full instant use in the case regency.  ain discussed during the exit 06/26/24 at 2:10 p.m. with the		same deficient practice will identified and what corrective action(s) will be taken; 100% audit of all areas for me of egress completed on 6/27/2. The two black plastic non-whote trash cans outside room #243 were immediately removed from blocking means of egress upon discovery on 6/26/24. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;	eans 24. eeled om
	Director of Nursing Supervisor.  3.1-19(b)	and the Maintenance		All Staff re-educated on K211 Means of Egress on or before 7/8/24(Attachment D). How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place; Maintenance director or desig will use the QA tool titled, "Life Safety Corrections 2024" 3x weekly for 4 weeks, 2 time we for 2 weeks then monthly thereafter as part of the facilit QAPI Program. Any concerns	the  out  inee e eekly

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet Page 15 of 21

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	·			COMPLI	ETED
		155557	B. WI	NG		06/26/	2024
	PROVIDER OR SUPPLIER			1651 N	ADDRESS, CITY, STATE, ZIP COD CAMPBELL ST APOLIS, IN 46218		
(X4) ID	SUMMARY !	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
					identified will be corrected upor discovery and findings documented on quality assurant log. All QA tools and findings we be reviewed monthly in the fact QAPI meeting to ensure ongoing compliance for a minimum of 60 months until the facility maintain 95% compliance for 60days. (Attachment C)	nce vill ility ng	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 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 6		K 03	351	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;		07/08/2024

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 16 of 21

PRINTED: 07/26/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155557 B. WING 06/26/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1651 N CAMPBELL ST

MILLER'S MERRY MANOR			INDIANAPOLIS, IN 46218		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION (X		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	escutcheons, or other devices used to cover the		The one-half inch gap observed		
	annular space around a sprinkler shall be metallic		around "far south" nurse station		
	or shall be listed for use around a sprinkler. This		sprinkler head was fixed upon		
	deficient practice could affect as many as 14		discovery on 6/26/24.		
	residents, 4 staff, and 2 visitors in the facility.		How other residents having the		
			potential to be affected by the		
	Findings include:		same deficient practice will be		
			identified and what corrective		
	Based on observations made during a tour of the		action(s) will be taken;		
	facility with the Maintenance Supervisor on		100% audit of all sprinkler heads		
	06/26/24 at 12:10 p.m., the small nurses' station on		completed on 6/27/24.		
	the "Far South" hall had a loose escutcheon.		The one-half inch gap observed		
	There was a visible gap of approximately one-half		around "far south" nurse station		
	inch of annular space around the sprinkler head.		sprinkler head was fixed upon		
	Based on interview at the time of observation, the		discovery on 6/26/24.		
	Maintenance Supervisor acknowledged the loose		What measures will be put into		
	escutcheon and advised that he would have it		place and what systemic		
	repaired as soon as possible.		changes will be made to		
			ensure that the deficient		
	This finding was again discussed during the exit		practice does not recur;		
	conference held on 06/26/24 at 2:10 p.m. with the		Maintenance director/assistants		
	Director of Nursing and the Maintenance		re-educated on K351: Sprinkler		
	Supervisor.		system on or before 7/8/24		
	2.1.10(1)		(Attachment D).		
	3.1-19(b)		How the corrective action(s)		
			will be monitored to ensure the		
			deficient practice will not		
			recur, i.e., what quality		
			assurance program will be put		
			into place; Maintenance director or designee		
			will use the QA tool titled, "Life		
			Safety Corrections 2024" 3x		
			weekly for 4 weeks, 2 time weekly		
			for 2 weeks then monthly		
			thereafter as part of the facility		
			QAPI Program. Any concerns		
			identified will be corrected upon		
			discovery and findings		
			documented on quality assurance		
		1	documented on quality assurance	1	

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 17 of 21

PRINTED: 07/26/2024

						1 141.1	ILD.	
EPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155557	B. WING			06/26/2024		
					_			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST					
MILLER'S	S MERRY MANOR		INDIANAPOLIS, IN 46218					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	. –	DATE	
					log All OA tools and findings y	azill .		

(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	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
PREFIX	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.  19.3.7.6, 19.3.7.8, 19.3.7.9  Based on observation and interview, the facility failed to ensure 1 of 6 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 28 residents, 6 staff, and 2 visitors.  Findings include:  Based on observations made during a tour of the	K 0374	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The latch on North Hall Barrier doors were fixed on 6/26/24 eliminating the one inch gap observed during survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	07/08/2024

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 18 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 01 COMPLI			ETED	
		155557	B. WING 06/26/2024			2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
MILLEDIA					CAMPBELL ST		
WIILLER	S MERRY MANOR			INDIAN	APOLIS, IN 46218		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility with the Ma	intenance Supervisor on			100% audit of barrier doors		
	06/26/24 at 12:52 p.	.m., the set of barrier doors on			completed on 6/27/24.		
	the North Hall did n	not fully close when tested			The latch on North Hall Barrie	r	
	three separate times	. There was a one-inch gap			doors were fixed on 6/26/24		
	between the doors v	when closed to their fullest.			eliminating the one inch gap		
	Based on interview	during the time of			observed during survey.		
	observation, the Ma	intenance Supervisor			What measures will be put in	ito	
	acknowledged these	e barrier doors did not close			place and what systemic		
	and seal completely	adding that he would have			changes will be made to		
	them looked at as so	oon as possible.			ensure that the deficient		
					practice does not recur;		
	This finding was ag	ain discussed during the exit			Maintenance director/assistan	t	
	conference held on	06/26/24 at 2:10 p.m. with the			re-educated on K374: Smoke		
	Director of Nursing	and the Maintenance			Barrier on or before 7/8/24		
	Supervisor.				(Attachment D).		
					How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place;		
					Maintenance director or desig	nee	
					will use the QA tool titled, "Life	;	
					Safety Corrections 2024" 3x		
					weekly for 4 weeks, 2 time we	ekly	
					for 2 weeks then monthly		
					thereafter as part of the facility	/	
					QAPI Program. Any concerns		
					identified will be corrected upo	n	
					discovery and findings		
					documented on quality assura	nce	
					log. All QA tools and findings v	will	
					be reviewed monthly in the fac	cility	
					QAPI meeting to ensure ongo	ing	
					compliance for a minimum of 6	3	
					months until the facility mainta		
					95% compliance for 60days.		
					(Attachment C)		
			1		<b>,</b>		

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

Event ID:

EVV021 Facility ID: 000500

If continuation sheet Page 19 of 21

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB	NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
155557		B. WING		06/26/2	024	
.0000			<u> </u>			
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
				CAMPBELL ST		
MILLER'S	MERRY MANOR		INDIAN	IAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	'E	DATE
K 0920	NFPA 101					,
SS=E	Electrical Equipme	ent - Power Cords and				
Bldg. 01	Extens					
	Electrical Equipme	ent - Power Cords and				
	Extension Cords					
	Power strips in a p	patient care vicinity are only				
	used for compone	-				
	· ·	ed electrical equipment				
	-	les that have been				
	assembled by qua	alified personnel and meet				
	the conditions of 1	0.2.3.6. Power strips in				
	the patient care vi	cinity may not be used for				
	non-PCREE (e.g.,	personal electronics),				
	except in long-terr	n care resident rooms that				
	do not use PCREI	E. Power strips for PCREE				
	meet UL 1363A or	r UL 60601-1. Power strips				
	for non-PCREE in	the patient care rooms				
	(outside of vicinity	) meet UL 1363. In				
	non-patient care r	ooms, power strips meet				
	other UL standard	ls. All power strips are				
	used with general	precautions. Extension				
	cords are not used	d as a substitute for fixed				
	wiring of a structu	re. Extension cords used				
	temporarily are re	moved immediately upon				
	completion of the	purpose for which it was				
	installed and mee	ts the conditions of 10.2.4.				
	10.2.3.6 (NFPA 99	9), 10.2.4 (NFPA 99), 400-8				
	(NFPA 70), 590.3	(D) (NFPA 70), TIA 12-5				
	Based on observation	on and interview, the facility	K 0920	K920		07/08/2024
	failed to ensure 1 of	f 1 Staffing Office did not use		What corrective action(s) wil	I	
	flexible cords as a s	substitute for fixed wiring. LSC		be accomplished for those		
	9.1.2 requires electr	rical wiring and equipment shall		residents found to have beer	1	
		ith NFPA 70, National		affected by the deficient		
		FPA 70, 2011 Edition, Article		practice;		
	-	unless specifically permitted,		The power strip in the Staffing	1	
		ables shall not be used as a		Office was immediately remov	'ed	
		wiring of a structure. This		upon discovery on 6/26/24.		
	•	ould affect 14 residents, 4 staff,		How other residents having t		
	and 2 visitors.			potential to be affected by th		
				same deficient practice will be	Эе	

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

Event ID:

EVV021

Facility ID: 000500

If continuation sheet

Page 20 of 21

07/26/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 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 06/26/2024 155557 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1651 N CAMPBELL ST MILLER'S MERRY MANOR INDIANAPOLIS, IN 46218 (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 Findings include: identified and what corrective action(s) will be taken; Based on observations made during a tour of the 100% audit of all areas for power facility with the Maintenance Supervisor on strips and cords completed on 06/26/24 at 12:52 p.m., a power strip was found to 6/27/24. be in use in the Staffing Office and had a mini The power strip in the Staffing refrigerator plugged into it. Based on interview at Office was immediately removed the time of the observation, the Maintenance upon discovery on 6/26/24. Supervisor acknowledged this instance of power What measures will be put into strip usage and immediately removed it from use place and what systemic and plugging the mini refrigerator directly into a changes will be made to wall outlet. ensure that the deficient practice does not recur; This finding was again discussed during the exit All staff re-educated on K920: conference held on 06/26/24 at 2:10 p.m. with the Electrical Equip-Power Cords on Director of Nursing and the Maintenance or before 7/8/24 (Attachment D). Supervisor. How the corrective action(s) will be monitored to ensure the 3.1-19(b) deficient practice will not recur, i.e., what quality assurance program will be put into place; Maintenance director or designee will use the QA tool titled, "Life Safety Corrections 2024" 3x weekly for 4 weeks, 2 time weekly for 2 weeks then monthly thereafter as part of the facility QAPI Program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum of 6 months until the facility maintains 95% compliance for 60days.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EVV021 Facility ID: 000500 Page 21 of 21 If continuation sheet

(Attachment C)