

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

PRINTED: 07/26/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/26/24</p> <p>Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220</p> <p>At this Emergency Preparedness survey, Miller's Merry Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 114 certified beds. At the time of the survey, the census was 53.</p> <p>Quality Review completed on 06/28/24</p>			E 0000	<p>Please find the enclosed Plan of Correction as the remedies to the deficiencies found during our Life Safety Code Recertification Survey with Emergency Preparedness Survey conducted on June 26, 2024. All areas have been corrected and effective systems and auditing tools are in place to prevent reoccurrence.</p>		
E 0004 SS=F Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency</p>						

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 30 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated</p>			E 0004	What corrective action(s) will be accomplished for those residents found to have been		07/08/2024

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

PRINTED: 07/26/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 06/26/24 between 9:12 a.m. to 9:37 a.m. with the Maintenance Supervisor, documentation for an updated Emergency Preparedness Plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 09/23/21. Based on interview at the time of record review, the Maintenance Supervisor agreed the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period based on the date written in the Emergency Preparedness binder.</p>				<p>affected by the deficient practice; The Emergency Preparedness plan was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error (Attachment A). Maintenance educated on location of updated documents. 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; All residents residing in the facility had the potential to be affected by this alleged deficient practice. The Emergency Preparedness plan was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. Maintenance educated on location of updated documents. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and maintenance director re-educated on Emergency Preparedness review on or before 7/8/24 (Attachment B). How the corrective action(s) will be monitored to ensure the deficient practice will not</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218		
(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 0013 SS=F Bldg. --	<p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the</p>		<p>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. (Attachment C)</p>		

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

PRINTED: 07/26/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, 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 annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency</p>						

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, 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.</p> <p>Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 06/26/24 between 9:12 a.m. to 9:37 a.m. with the Maintenance Supervisor, documentation for updated policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 09/23/21. Based on interview at the time of record review, the Maintenance Supervisor agreed the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period based on the date written in the Emergency Preparedness binder.</p>			E 0013	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The Emergency Preparedness plan including policies and procedures was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. (Attachment A). Maintenance educated on location of updated documents.</p> <p>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;</p> <p>All residents residing in the facility had the potential to be affected by this alleged deficient practice. The Emergency Preparedness plan including policies and procedures was reviewed on</p>		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218		
(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	
			5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. Maintenance educated on location of updated documents. What measures will be put into 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 Policies and Procedures review on or before 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 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. (Attachment C)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0029 SS=F Bldg. --	<p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 06/26/24 between 9:12 a.m. to 9:37 a.m. with the Maintenance Supervisor, documentation for an updated communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 09/23/21. Based on interview at the time of record review, the Maintenance Supervisor agreed the facility has not had its entire emergency preparedness</p>			E 0029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The Emergency Preparedness plan including communication plan was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. (Attachment A). Maintenance educated on location of updated documents.</p> <p>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;</p>		07/08/2024

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

PRINTED: 07/26/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218		
(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	
	program reviewed by the facility within the most recent twelve-month period based on the date written in the Emergency Preparedness binder.		<p>All residents residing in the facility had the potential to be affected by this alleged deficient practice. The Emergency Preparedness plan including communication plan was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. Maintenance educated on location of updated documents.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator & maintenance director re-educated on Emergency Communication plan review on or before 7/8/24 (Attachment B).</p> <p>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 log. All QA tools and findings will</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218		
(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 0036 SS=F Bldg. --	<p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training</p>		<p>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. (Attachment C)</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p>						

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness testing and training program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 06/26/24 between 9:12 a.m. to 9:37 a.m. with the Maintenance Supervisor, documentation for an updated testing and training program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve months with a last documented review date listed as 09/23/21. Based on interview at the time of record review, the Maintenance Supervisor agreed the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period based on the date written in the Emergency Preparedness binder.</p>			E 0036	<p>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 training was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. (Attachment A). Maintenance educated on location of updated documents.</p> <p>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; All residents residing in the facility had the potential to be affected by this alleged deficient practice. The Emergency Preparedness plan including testing and training was reviewed on 5/15/24 per signature sheet. This sheet was available at the time of survey but the incorrect sheet from 9/23/21 was given to surveyor in error. Maintenance educated on location of updated documents.</p> <p>What measures will be put into 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</p>		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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 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: 06/26/24 Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220			K 0000	and training review on or before 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 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. (Attachment C) Please find the enclosed Plan of Correction as the remedies to the deficiencies found during our Life Safety Code Recertification Survey with Emergency Preparedness Survey conducted on June 26, 2024. All areas have been corrected and effective systems and auditing tools are in place to prevent reoccurrence.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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 0211 SS=E Bldg. 01	<p>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.</p> <p>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.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.</p> <p>Quality Review completed on 06/28/24</p> <p>NFPA 101 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 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions</p>			K 0211	What corrective action(s) will be accomplished for those residents found to have been		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors in the facility.</p> <p>Findings include:</p> <p>Based on the initial walk through of the facility from 9:00 a.m. to 9:08 a.m. on 06/26/24, two black plastic non-wheeled trash cans were stored in the corridor immediately outside resident room #243. Based on observations with the Maintenance Supervisor during a tour of the facility on 06/26/24 at 12:15 p.m., the two black trash cans were still located in the corridor outside of resident room #243. Based on interview at the time of the observation, the Maintenance Supervisor agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to allow full instant use in the case of fire or other emergency.</p> <p>This finding was again discussed during the exit conference held on 06/26/24 at 2:10 p.m. with the Director of Nursing and the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				<p>affected by the deficient practice; The two black plastic non-wheeled trash cans outside room #243 were immediately removed from blocking means of egress upon discovery on 6/26/24. 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; 100% audit of all areas for means of egress completed on 6/27/24. The two black plastic non-wheeled trash cans outside room #243 were immediately removed from blocking means of egress upon discovery on 6/26/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 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 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</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0351 SS=E Bldg. 01	<p>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 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates,</p>			K 0351	<p>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. (Attachment C)</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p>		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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	
	<p>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 14 residents, 4 staff, and 2 visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/24 at 12:10 p.m., the small nurses' station on the "Far South" hall had a loose escutcheon. There was a visible gap of approximately one-half inch of annular space around the sprinkler head. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the loose escutcheon and advised that he would have it repaired as soon as possible.</p> <p>This finding was again discussed during the exit conference held on 06/26/24 at 2:10 p.m. with the Director of Nursing and the Maintenance Supervisor.</p> <p>3.1-19(b)</p>			<p>The one-half inch gap observed around "far south" nurse station sprinkler head was fixed upon discovery on 6/26/24.</p> <p>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;</p> <p>100% audit of all sprinkler heads completed on 6/27/24.</p> <p>The one-half inch gap observed around "far south" nurse station sprinkler head was fixed upon discovery on 6/26/24.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Maintenance director/assistants re-educated on K351: Sprinkler system on or before 7/8/24 (Attachment D).</p> <p>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;</p> <p>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</p>			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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 0374 SS=E Bldg. 01	<p>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 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.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the</p>			K 0374	<p>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. (Attachment C)</p> <p>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;</p>		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(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
	<p>facility with the Maintenance Supervisor on 06/26/24 at 12:52 p.m., the set of barrier doors on the North Hall did not fully close when tested three separate times. There was a one-inch gap between the doors when closed to their fullest. Based on interview during the time of observation, the Maintenance Supervisor acknowledged these barrier doors did not close and seal completely adding that he would have them looked at as soon as possible.</p> <p>This finding was again discussed during the exit conference held on 06/26/24 at 2:10 p.m. with the Director of Nursing and the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				<p>100% audit of barrier doors completed on 6/27/24. The latch on North Hall Barrier doors were fixed on 6/26/24 eliminating the one inch gap observed during survey. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director/assistant re-educated on K374: Smoke Barrier on or before 7/8/24 (Attachment D). 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 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. (Attachment C)</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>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) assemblies 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 Staffing Office did not use flexible cords 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 for fixed wiring of a structure. This deficient practice could affect 14 residents, 4 staff, and 2 visitors.</p>			K 0920	<p>K920 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The power strip in the Staffing Office was immediately removed upon discovery on 6/26/24. How other residents having the potential to be affected by the same deficient practice will be</p>		07/08/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 06/26/2024	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Findings include:</p> <p>Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/24 at 12:52 p.m., a power strip was found to be in use in the Staffing Office and had a mini refrigerator plugged into it. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged this instance of power strip usage and immediately removed it from use and plugging the mini refrigerator directly into a wall outlet.</p> <p>This finding was again discussed during the exit conference held on 06/26/24 at 2:10 p.m. with the Director of Nursing and the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				<p>identified and what corrective action(s) will be taken; 100% audit of all areas for power strips and cords completed on 6/27/24. The power strip in the Staffing Office was immediately removed upon discovery on 6/26/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff re-educated on K920: Electrical Equip-Power Cords on or before 7/8/24 (Attachment D). 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 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. (Attachment C)</p>		