PRINTED: 06/20/2023 FORM APPROVED

CENTERS FOI	NTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155557	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/30/2023				
	PROVIDER OR SUPPLIER S MERRY MANOR		STREET 1651 N INDIAI						
(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				
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 05/30 Facility Number: 0 Provider Number: 100 At this Emergency Merry Manor was f Emergency Prepare Medicare and Medi and Suppliers, 42 C The facility has 114 the survey, the cens	20/23 200500 155557 266220 Preparedness survey, Miller's found in compliance with edness Requirements for caid Participating Providers FR 483.73.	E 0000	Please find the enclosed Plar Correction as remedies to the deficiencies found during our Safety Code Recertification S with Emergency Preparednes Survey conducted on May 30,2023. We respectfully required consideration for Paper Compliance in lieu of revisit. A areas have been corrected an effective systems and auditing tools are in place to prevent reoccurrence.	e Life Survey ss uest All				
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/30 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety 0	00500 155557	K 0000	Please find the enclosed Plar Correction as remedies to the deficiencies found during our Safety Code Recertification S with Emergency Preparednes Survey conducted on May 30,2023. We respectfully required consideration for Paper Compliance in lieu of revisit. A areas have been corrected an effective systems and auditing tools are in place to prevent reoccurrence.	E Life Survey SS Luest All				

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

(X6) DATE

Jance Peterson Administrator 06/13/2023

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155557	B. WI	NG		05/30/	2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP COD CAMPBELL ST		
MILLER'S MERRY MANOR					APOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Requirements for Pa	•					
		, 42 CFR Subpart 483.90(a),					
	•	re and the 2012 Edition of the					
		etion Association (NFPA) 101, SC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	ricaitii Care Occupa	meles and 410 IAC 10.2.					
	This facility, with a	two story center section and					
	-	s, was determined to be of					
		ruction and fully sprinklered.					
	The facility has a fir	re alarm system with smoke					
	detection in the corr	ridors and in all areas open to					
		icility has battery operated					
		all 60 resident sleeping rooms.					
	•	apacity of 114 and had a					
	census of 57 at the t	time of this visit.					
	All areas where resi	dents have customary access					
		The facility has one detached					
	-	storage services which was					
	not sprinklered.	storage services which was					
	not springered.						
	Quality Review con	npleted on 06/01/23					
K 0281	NFPA 101						
SS=E	Illumination of Mea	ans of Egress					
Bldg. 01	Illumination of Mea	-					
		ans of egress, including exit					
	_	nged in accordance with 7.8					
		r continuously in operation					
	3	matic operation without					
	manual intervention	on.					
	18.2.8, 19.2.8	on and interview, the facility	K 02	201	K281 Illumination Means of		06/15/2023
		ess lighting for 1 of 11 exit	K U.	201	Egress		00/13/2023
		s arranged so the failure of			What corrective action(s	,	
		fixture (bulb) would not leave			will be accomplished for those	<i>'</i>	
		. LSC 7.8.1.4 requires			residents found to have been		
		e arranged so that that the			affected by the deficient practi	ce;	
	failure of any single	e lighting unit does not result			The light bulb that was burned	out	
			1				

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Event ID:

FNXI21

Facility ID: 000500

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES						
CTATEMENT OF DEFICIENCIES	V1) DD OVIDED (CLIDDLIED (C					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155557		IDENTIFICATION NUMBER	l í	JILDING	INSTRUCTION 01	(X3) DATE : COMPL 05/30 /	ETED
NAME OF D	PROVIDER OR SUPPLIER		D. W.	_	ADDRESS, CITY, STATE, ZIP COD	03/30/	2020
	S MERRY MANOR				CAMPBELL ST APOLIS, IN 46218		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	in an illumination lo in any designated a	evel of less than 0.2 foot-candle rea. This deficient practice		TAG	near the 225 room exit was replaced on 6/8/2023.		DATE
		residents, staff and visitors in g to exit the facility by the exit			 How other residents hav the potential to be affected by same deficient practice will be identified and what corrective 	-	
	Findings include:	ons with the Administrator			action(s) will be taken; 20 resident that reside on the linear the exit could have been	unit	
	and the Maintenanc facility from 1:00 p	e Director during a tour of the .m. to 3:20 p.m. on 05/30/23, the exit by Room 225 is			affected by this deficient practi The light bulb that was burned near the 225 room exit was		
	equipped with two sfixtures each contain	separate wall mounted lighting ning a single light bulb. One			replaced on 6/8/2023. · What measures will be p	ut	
	was burnt out. Base the observations, th	ninated and the other light bulb ed on interview at the time of e Maintenance Director agree			into place and what systemic changes will be made to ensur the deficient practice does not		
	_	light bulbs in the exit oom 225 was not burnt out.			recur; Maintenance director re-educa on "General Building" policy ar		
	These findings were Administrator and t during the exit conf	he Maintenance Director			procedure for proper exterior lighting on or before 6/15/2023 (Attachment A)	3.	
	3.1-19(b)				 How the corrective action 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 design will use the QA tool titled, "Life Safety Correction 2023" 3x		
					weekly for 2 weeks, 1 time wer for 2 weeks and then monthly thereafter as part of the facility		
					QAPI program. Any concerns identified will be corrected upo discovery and findings		
					documented on quality assura tracking log. All QA tools and	nce	
M CMS-2567(02	2-99) Previous Versions Ob	solete Event ID: F	NXI21	Facility I	ID: 000500 If continuation sl	neet Pag	ge 3 of 9

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PRINTED: 06/20/2023

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 CO	OMB NO. 0938-039 ATE SURVEY OMPLETED 5/30/2023	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) findings will be reviewed monthly		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG findings will be reviewed monthly		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) findings will be reviewed monthly		
	(X5) COMPLETION DATE	
K 0300 SS=C Bldg. 01 NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 60 of 60 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke	DATE 06/15/2023	
alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. All residents residing in the facility had the potential to be affected by this deficient practice. All 60 battery operated smoke detectors were replaced on		

Based on observations with the Administrator and the Maintenance Director at 3:37 p.m. on

the First Alert Model SA 340 battery operated

05/30/23, manufacturer's documentation affixed to

What measures will be put

into place and what systemic

changes will be made to ensure

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155557	A. BUILDING B. WING	01	COMPLETED 05/30/2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
MILLER'S	S MERRY MANOR			IAPOLIS, IN 46218	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		ed on the ceiling in resident	IAG	the deficient practice does not	
		indicated it was manufactured		recur;	
	04/25/13. The man	ufacturer's documentation also		Maintenance director re-educa	ated
	_	date is 10 years after		on the "Battery Operated Smo	ke
		stallation date of "11/13" was		Detector Policy" on or before	
		of the smoke alarm. Based on		6/15/2023. (Attachment C)	
		e of the observations, the		· How the corrective actio	
		or stated the facility has a		will be monitored to ensure the	=
		sleeping rooms, the same type		deficient practice will not recu	r,
		nstalled in each sleeping room		i.e. what quality assurance	
	and all the smoke al			program will be put into place;	
		nd installation date. The		Maintenance director or desig	
		he Maintenance Director		will use the QA tool titled, "Life	
		aware of the 10 year		Safety Correction 2023" 3x	- Lab.
		ment and is scheduled to		weekly for 2 weeks, 1 time we	•
	_	alarm in November 2023 which fter installation. Based on		for 2 weeks and then monthly	
		e of the observations, the		thereafter as part of the facility QAPI program. Any concerns	′
		or agreed the manufacture		identified will be corrected upo	on l
		eping room battery operated		discovery and findings	
		led in the facility was more		documented on quality assura	unce
	than ten years old.	ied in the facility was more		tracking log. All QA tools and	
	than ten years ora.			findings will be reviewed month	thly
	These findings were	e reviewed with the		in the facility QAPI meeting to	any
		he Maintenance Director		ensure ongoing compliance for	nra
	during the exit confe			minimum 6 months and until the	
	8			facility maintains 95% complia	
	3.1-19(b)			for 60 days. (Attachment B)	
K 0324	NFPA 101				
SS=D	Cooking Facilities				
Bldg. 01	Cooking Facilities				
	Cooking equipmer	nt is protected in			
	•	IFPA 96, Standard for			
		I and Fire Protection of			
		ing Operations, unless:			
		ng equipment (i.e., small			
		s microwaves, hot plates,			
		for food warming or limited			
	cooking in accorda	ance with 18.3.2.5.2,			
1					1

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	T OF DEFICIENCIES		ara) :	ON LOTTING LOTTING Y	OVID NO. 0936-039	
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
155557		B. WING		05/30/2023		
	PROVIDER OR SUPPLIER	2	1651 N	ADDRESS, CITY, STATE, ZIP COD I CAMPBELL ST		
MILLER'S MERRY MANOR			INDIAN	NAPOLIS, 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 APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	smoke compartments patients comply with 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer productions under a Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazard be open to the cooling through 19.3.2.5.5. Based on record revision of the confacilities in Section 11.4 states to be inspected for great trained, qualified, a acceptable to the aurand in accordance with Schedule for Inspection, if the expection, if the expection, if the expection of the contaminated with a	atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be rdous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 view and interview, the facility f 1 kitchen exhaust systems annually. NFPA 96, 2011 or Ventilation Control and Fire mercial Cooking Operations, the entire exhaust system shall case buildup by a properly nd certified person(s) atthority having jurisdiction with Table 11.4. Table 11.4, ction for Grease Buildup, rving moderate volume shall be inspected A 96, 11.6.1 states, upon chaust system is found to be deposits from grease laden nated portions of the exhaust aned by a properly trained, fied person(s) acceptable to the risdiction. Hoods, grease	K 0324	K324 Cooking Facilities What corrective action(s will be accomplished for those residents found to have been affected by the deficient pract Semi-Annual hood inspection completed on 3/17/23. The nethood inspection is scheduled 9/1/23 How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fahad the potential to be affected this deficient practice. Semi-Annual hood inspection completed on 3/17/23. The nethood inspection is scheduled 9/1/23 What measures will be printo place and what systemic changes will be made to ensure the deficient practice does not recur;	ice; was ext for ving the e cility d by was ext for	

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Event ID:

FNXI21

Facility ID: 000500

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155557	B. W	B. WING 05/30/2023			
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CAMPBELL ST		
MILLEDIS	S MERRY MANOR				IAPOLIS, IN 46218		
IVIILLLIX	S WENT WANTE			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	substance. When ar	exhaust cleaning service is			Maintenance supervisor		
		howing the name of the			re-educated on "Kitchen Area		
		the name of the person			Procedure" on or before 6/15/2	2023.	
	performing the wor	k, and the date of inspection or			(Attachment D)		
	cleaning shall be m	aintained on the premises.			 How the corrective actio 	n(s)	
	This deficient pract	ice could affect over two staff			will be monitored to ensure the	3	
	in the kitchen.				deficient practice will not recui	•,	
					i.e. what quality assurance		
	Findings include:				program will be put into place;		
					Maintenance director or desig	nee	
	Based on review of	the kitchen range hood			will use the QA tool titled, "Life	;	
		or's "Job Service Report"			Safety Correction 2023" 3x		
	documentation date	ed 03/17/23 with the			weekly for 2 weeks, 1 time we	ekly	
	Administrator and t	he Maintenance Director			for 2 weeks and then monthly		
	during record revie	w from 9:20 a.m. to 1:00 p.m. on			thereafter as part of the facility	/	
	05/30/23, documen	tation of a semiannual kitchen			QAPI program. Any concerns		
	exhaust system insp	pection six months prior to			identified will be corrected upo	n	
	03/17/23 was not av	vailable for review. Based on			discovery and findings		
	interview at the tim	e of record review, the			documented on quality assura	nce	
		tor agreed documentation of a			tracking log. All QA tools and		
		exhaust system inspection six			findings will be reviewed mont	hly	
	months prior to 03/	17/23 was not available for			in the facility QAPI meeting to		
	review.				ensure ongoing compliance for	r a	
					minimum 6 months and until the	те	
	These findings were				facility maintains 95% complia	nce	
		he Maintenance Director			for 60 days. (Attachment B)		
	during the exit conf	Perence.					
	3.1-19(b)						
K 0761							
SS=E							
Bldg. 01						_	
		view and interview, the facility	K 0	761	K761 Maintenance, Inspection	ı &	06/15/2023
		ual inspection and testing of			Testing – Doors		
		blies were completed in			· What corrective action(s	,	
		19.1.1.4.1.1. Communicating			will be accomplished for those)	
		g fire barriers required by			residents found to have been		
	-	permitted only in corridors and			affected by the deficient practi		
	shall be protected b	y approved self-closing fire			Annual door inspection for all	fire	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
	155557 B. WING			05/30/	2023		
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			CAMPBELL ST		
MILLER'S	S MERRY MANOR				IAPOLIS, IN 46218		
				1	1	are:	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	,	ee also Section 8.3.) LSC			door assemblies were		
		quired to have a fire protection			re-completed on 6/13/2023.		
		4.2 shall be protected by			(Attachment E)	din a	
		peled fire door assemblies and plies and their accompanying			How other residents have	-	
		g all frames, closing devices,			the potential to be affected by		
		in accordance with the			same deficient practice will be	;	
	_	PA 80, Standard for Fire Doors			identified and what corrective		
		Protectives, except as			action(s) will be taken;	oilitu	
		in this Code. NFPA 80,			All residents residing in the factor	•	
	_	fire door assemblies shall be			had the potential to be affecte	u by	
		Inter door assemblies shall be a not less than annually, and a			this deficient practice.	fire	
	_	e inspection shall be signed			Annual door inspection for all	ille	
		tion by the AHJ. NFPA 80,			door assemblies were		
		oor assemblies shall be visually			re-completed on 6/13/2023.		
		sides to assess the overall			(Attachment E)	S. 14	
	condition of door as				· What measures will be p	Jul	
	condition of door as	ssemory.			into place and what systemic	ro	
	NEDA SO Soction 5	5.2.4.2 states as a minimum tha			changes will be made to ensu		
	following items sha	5.2.4.2 states as a minimum, the			the deficient practice does not	L	
	_	or breaks exist in surfaces of			recur;	_	
	either the door or fr				Maintenance supervisor will b		
		ame. light frames, and glazing beads			re-educated on the "Annual D		
		ely fastened in place, if so			Inspection" on or before 6/15/3 (Attachment F)	2023	
	equipped.	cry rastened in place, it so			· How the corrective actio	n(c)	
		, hinges, hardware, and			will be monitored to ensure the		
		eshold are secured, aligned,					
		er with no visible signs of			deficient practice will not recu	١,	
		or with no visione signs of			i.e. what quality assurance		
	damage. (4) No parts are mis	ssing or broken			program will be put into place; Maintenance director or desig		
		do not exceed clearances			will use the QA tool titled, "Life		
	listed in 4.8.4 and 6				Safety Correction 2023" 3x	-	
		device is operational; that is,			weekly for 2 weeks, 1 time we	okly	
	1 ' '	pletely closes when operated			for 2 weeks and then monthly	CRIY	
	from the full open p				thereafter as part of the facility	,	
		is installed, the inactive leaf			QAPI program. Any concerns	′	
	closes before the ac				identified will be corrected upo	nn l	
		are operates and secures the			discovery and findings	ווע	
	door when it is in the				_	nce	
		vare items that interfere or			documented on quality assura	ii iC C	
	L VIII LUADIA V HAILIW	are neing mar michicle of			c		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
155557		IDENTIFICATION NUMBER 155557	A. BUILDING B. WING	01	COMPLETED 05/30/2023			
		.55001		ADDRESS SITE OF THE SITE OF	30,00,2020			
NAME OF I	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD 1651 N CAMPBELL ST					
MILLER'S MERRY MANOR			INDIAN	IAPOLIS, IN 46218				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
1.40	prohibit operation a frame. (10) No field modification have been performed (11) Gasketing and inspected to verify. This deficient pract residents, staff and Bistro by the Main Findings include: Based on review of Door Assembly Instead documentation date Administrator and the during record review 05/30/23, annual fired documentation for "Opening Location" "Compliant? Yes" of inspection documents the results of all instead the time of record report were left the time of record rec	ire not installed on the door or installed on the door or installed that void the label. edge seals, where required, are their presence and integrity. ice could affect over 20 visitors in the vicinity of the Dining Room. I''Detailed Checklist for Fire pection (FDAI)" and 04/12/23 with the he Maintenance Director for from 9:20 a.m. to 1:00 p.m. on the door inspection to be inspection to be inspection to the installed the maintenance of the installed the maintenance it in and testing items in blank. Based on interview at eview, the Maintenance tional fire door inspection to pening #: 10A" within the month period was not and agreed fire door installed lank. The installed on the inspection to the inspection of the inspection of the inspection the inspection of		findings will be reviewed montin the facility QAPI meeting to ensure ongoing compliance for minimum 6 months and until the facility maintains 95% compliator 60 days. (Attachment B)	hly or a he			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FNXI21 Facility ID: 000500 If continuation sheet Page 9 of 9