STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155557	A. BUILDING -- B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/30/23 Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220 At this Emergency Preparedness survey, Miller's Merry Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 57. Quality Review completed on 06/01/23	E 0000	Please find the enclosed Plan of Correction as remedies to the deficiencies found during our Life Safety Code Recertification Survey with Emergency Preparedness Survey conducted on May 30,2023. We respectfully request consideration for Paper Compliance in lieu of revisit. All areas have been corrected and effective systems and auditing tools are in place to prevent reoccurrence.	
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: 05/30/23 Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with	K 0000	Please find the enclosed Plan of Correction as remedies to the deficiencies found during our Life Safety Code Recertification Survey with Emergency Preparedness Survey conducted on May 30,2023. We respectfully request consideration for Paper Compliance in lieu of revisit. All areas have been corrected and effective systems and auditing tools are in place to prevent reoccurrence.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jance Peterson	Administrator	06/13/2023

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), 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 one detached building providing storage services which was not sprinklered. Quality Review completed on 06/01/23			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure egress lighting for 1 of 11 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result	K 0281	K281 Illumination Means of Egress · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The light bulb that was burned out	06/15/2023

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	in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 20 residents, staff and visitors in the facility if needing to exit the facility by the exit door by Room 225. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:20 p.m. on 05/30/23, the exit discharge for the exit by Room 225 is equipped with two separate wall mounted lighting fixtures each containing a single light bulb. One light bulb was illuminated and the other light bulb was burnt out. Based on interview at the time of the observations, the Maintenance Director agree only one of the two light bulbs in the exit discharge outside Room 225 was not burnt out. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		near the 225 room exit was replaced on 6/8/2023. · 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; 20 resident that reside on the unit near the exit could have been affected by this deficient practice. The light bulb that was burned out near the 225 room exit was replaced on 6/8/2023. · What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur; Maintenance director re-educated on “General Building” policy and procedure for proper exterior lighting on or before 6/15/2023. (Attachment A) · 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 Correction 2023” 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and	

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			findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment B)	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other 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 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. Findings include: Based on observations with the Administrator and the Maintenance Director at 3:37 p.m. on 05/30/23, manufacturer's documentation affixed to the First Alert Model SA 340 battery operated	K 0300	K300 Protection · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All 60 battery operated smoke detectors were replaced on 6/9/2023. · 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 deficient practice. All 60 battery operated smoke detectors were replaced on 6/9/2023. · What measures will be put into place and what systemic changes will be made to ensure	06/15/2023

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	smoke alarm installed on the ceiling in resident sleeping Room 202 indicated it was manufactured 04/25/13. The manufacturer's documentation also stated "replacement date is 10 years after installation". An installation date of "11/13" was written on the back of the smoke alarm. Based on interview at the time of the observations, the Maintenance Director stated the facility has a total of 60 resident sleeping rooms, the same type of smoke alarm is installed in each sleeping room and all the smoke alarms have the same manufacture date and installation date. The Administrator and the Maintenance Director stated the facility is aware of the 10 year replacement requirement and is scheduled to replace each smoke alarm in November 2023 which would be 10 years after installation. Based on interview at the time of the observations, the Maintenance Director agreed the manufacture date for resident sleeping room battery operated smoke alarms installed in the facility was more than ten years old. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the deficient practice does not recur; Maintenance director re-educated on the “Battery Operated Smoke Detector Policy” on or before 6/15/2023. (Attachment C) · 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 Correction 2023” 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment B)	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2,			

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	19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other	K 0324	K324 Cooking Facilities · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Semi-Annual hood inspection was completed on 3/17/23. The next hood inspection is scheduled for 9/1/23 · 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 deficient practice. Semi-Annual hood inspection was completed on 3/17/23. The next hood inspection is scheduled for 9/1/23 · What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur;	06/15/2023

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	substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect over two staff in the kitchen. Findings include: Based on review of the kitchen range hood inspection contractor's "Job Service Report" documentation dated 03/17/23 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 1:00 p.m. on 05/30/23, documentation of a semiannual kitchen exhaust system inspection six months prior to 03/17/23 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation of a semiannual kitchen exhaust system inspection six months prior to 03/17/23 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance supervisor re-educated on “Kitchen Area Procedure” on or before 6/15/2023. (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 Correction 2023” 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment B)	
K 0761 SS=E Bldg. 01	Based on record review and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire	K 0761	K761 Maintenance, Inspection & Testing – Doors · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Annual door inspection for all fire	06/15/2023

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	door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Section 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or		door assemblies were re-completed on 6/13/2023. (Attachment E) · 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 deficient practice. Annual door inspection for all fire door assemblies were re-completed on 6/13/2023. (Attachment E) · What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur; Maintenance supervisor will be re-educated on the “Annual Door Inspection” on or before 6/15/2023 (Attachment F) · 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 Correction 2023” 3x weekly for 2 weeks, 1 time weekly for 2 weeks and then monthly thereafter as part of the facility QAPI program. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and	

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	prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Bistro by the Main Dining Room. Findings include: Based on review of "Detailed Checklist for Fire Door Assembly Inspection (FDAI)" documentation dated 04/12/23 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 1:00 p.m. on 05/30/23, annual fire door inspection documentation for "Opening #: 10A" at the "Opening Location: Bistro" was incomplete. The "Compliant? Yes" or "No" section of the inspection documentation was not checked and the results of all inspection and testing items in the report were left blank. Based on interview at the time of record review, the Maintenance Director stated additional fire door inspection documentation for "Opening #: 10A" within the most recent twelve month period was not available for review and agreed fire door inspection documentation for the fire door listed as "10A" was left blank. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		findings will be reviewed monthly in the facility QAPI meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 95% compliance for 60 days. (Attachment B)	