		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155235	B. WI	NG		05/27/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.		200 261			
MILLER'S	S MERRY MANOR				SPORT, IN 46947		
(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 APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	GULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)			DATE		
E 0000							
Dida							
Bldg	Am Emanagamay Duan	and de and Criminal rules	E 00	000	On May 27, 2025, an annual li	£_	
		paredness Survey was diana Department of Health in	E 00	JUU	On May 27, 2025, an annual li safety code survey was	ie	
	accordance with 42	-			conducted. A plan of correction	n	
	accordance with 42	C1 K 703./3.			was formally implemented upo		
	Survey Date: 05/27/	/25			receipt of the CMS Form 2567		
	5				Attached is the plan of correct		
	Facility Number: 00	00140			all pertinent attachments, and		
	Provider Number: 1				facility representative's signatu		
	AIM Number: 100266960				on page one of the 2567. Plea		
					review the submitted plan of		
	At this Emergency l	Preparedness survey, Miller's			correction to the cited deficien	cies	
	-	ound in compliance with			and contact us should you hav		
	Emergency Preparedness Requirements for				any questions following the rev	view	
		caid Participating Providers			of the plan of correction.		
		FR 483.73. The facility has a					
		had a census of 87 at the time					
	of this survey.						
	Quality Review con	nnleted on 06/02/25					
	Quanty Keview con	inpleted on 00/02/23					
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 00	000	On May 27, 2025, an annual li	fe	
		as conducted by the Indiana			safety code survey was		
	Department of Heal	th in accordance with 42 CFR			conducted. A plan of correction	n	
	483.90(a).				was formally implemented upo	n	
					receipt of the CMS Form 2567		
	Survey Date: 05/27/	/25			Attached is the plan of correct		
		224			all pertinent attachments, and		
	Facility Number: 00				facility representative's signatu		
	Provider Number: 1				on page one of the 2567. Plea	se	
	AIM Number: 1002	.0070U			review the submitted plan of	oioo	
	At this Life Sofety	Code survey, Miller's Merry			correction to the cited deficien		
		ot in compliance with			and contact us should you have any questions following the rev		
	Requirements for Pa	-			of the plan of correction.	VICW	
	1.cquirements 101 17						

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

(X6) DATE

TITLE

Zackary Freel Administrator 06/13/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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 XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 05/27/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Life Safety from Fir National Fire Protec Life Safety Code (L	, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, .SC), Chapter 19, Existing ancies and 410 IAC 16.2.				
	different construction existing health care building with a part to be of Type II (11 sprinklered. Building addition one story but of Type V (111) contribution.	s of two buildings with on types. Building One, the and memory care three story ial basement was determined 1) construction and fully ground Two, the new therapy building was determined to be instruction and fully sprinklered, separated by a two-hour fire				
	detection in the corr corridors, and batter in the sleeping room	fire alarm system with smoke ridors, spaces open to the ry-operated smoke detectors as. The facility has a capacity nsus of 87 at the time of this				
		residents have customary ered. All areas providing re sprinklered.				
	Quality Review con	npleted on 06/02/25				
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress -	- General				
g. 9 .	failed to ensure 1 of kitchen had a releas use of special know accordance with 7.2 Assembly Requiren	on and interview, the facility f 3 exit discharges doors in the sing device that did not require ledge or extra effort in 2.1.4 Swinging-Type Door ment. 7.2.1.4.1 (3) (d) states es shall be operable from within	K 0211	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. The doorknob was immediate replaced with one that does n take extra effort or special	so vays ely	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155235	B. W	ING		05/27/	2025
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
MILLEDIO	S MEDDY MANOD		200 26TH ST				
	S MERRY MANOR			LOGANSPORT, IN 46947			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ne use of any special	+	TAG			DATE
		t. This deficient practice could			knowledge to unlock the door		
	_	tchen using the back exit door			handle and exit the kitchen.	al ta	
	during an emergenc	_			All residents have the potentia	ai to	
	during an emergenc	y.			be affected by this deficient practice. All exit doors have the		
	Findings include:				potential to be affected by the		
	i mamga metade.				same deficient practice. A full		
	Based on observation	ons with the Maintenance			audit of all the exit doors was		
		Iministrator on 05/27/25 at			conducted. No other exit doors	s	
		the back exit door in the kitchen			were affected.	-	
	· /	rveyor, the door would not			To ensure that the deficient		
		ered the doorknob had a turn			practice does not recur all stat	ff will	
	_	at did not unlock when the			be in-serviced on the NFPA		
	knob was twisted ar	nd the lock had to be manually			regulations (Attachment A and	d	
	turned. This conditi	on requires extra effort to			A1).		
	open the door and c	ould delay exiting the kitchen			To monitor the corrective acti	ons	
	during an emergenc	y. Based on an interview at			and ensure the deficient pract	ice	
	12:42 a.m., the Mai	ntenance director agreed in			will not recur, the ADM /Desig	nee	
		tit door, it took extra effort or			will complete the QA Tool title	d	
		to unlock and turn the door			Annual Survey 05/27/25 Track		
	handle to exit the ki	tchen.			(Attachment C). This tool will t		
					completed daily (5 days/week		
	The findings were r				2 weeks, then weekly for 6 we		
		The Maintenance Director			then monthly for 4 months, an		
	during the exit conf	erence at 3:10 p.m.			quarterly thereafter and will be	9	
	2.1.10(1)				reviewed in one year by the		
	3.1-19(b)				Quality Assurance (QA) team		
					determine the frequency of the	9	
					audit. Any concerns will be	0.40	
					addressed immediately and ha		
					Quality Assurance and Quality Improvement Action Plan	′	
					completed. The action plan wi	ll he	
					reviewed at the monthly QAPI		
					meeting with changes made a		
					appropriate.		
K 0223	NFPA 101						
SS=E	Doors with Self-Cl	losing Devices					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED
		155235	B. Wl	NG		05/27/	2025
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
MILLEDIO	NEDDY MANOD			200 26			
WILLER	S MERRY MANOR			LOGAN	ISPORT, IN 46947		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)	1.5	DATE
Bldg. 01							
· ·	Based on observation	on and interview, the facility	K 0	223	It is the policy of Miller's Merry	,	06/27/2025
		2 Hazardous storage room	110		Manor to operate in a fashion		00/27/2020
		e second floor was not			the safety of the residents alw		
		sing. This deficient practice			comes first.	ayo	
		in one smoke compartment.			Comes mat.		
	affects 25 residents	in one smoke compartment.			The shain helding the door on	on	
	Fig. 41				The chain holding the door op		
	Findings include:				was immediately taken away a	and	
	D 1 1	et da a serve			the door was closed.		
		ation with the Maintenance					
		ministrator on 05/27/25 at			All residents have the potentia	ıl to	
	12:15 p.m., the second floor housekeeping room				be affected by this deficient		
	contained over 10 boxes of combustible supplies,				practice. All hazardous storag		
	flammable aerosol cans, and was greater than 50			areas have the potential to be			
		this a hazardous area. The			affected by the same deficient		
		as self-closing but the door			practice. A full audit of all the		
		chain wrapped around the		hazardous storage areas was			
	door handle. Based	on interview at 12:15 p.m., the			conducted. No other hazardou	IS	
	Maintenance Direct	or agreed the housekeeping			storage areas were affected.		
	room contained con	nbustible storage, was larger					
	than 50 square feet,	and the corridor door to the					
	room was held open	with a chain.			To ensure that the deficient		
					practice does not recur all stat	f will	
	The findings were r	eviewed with the			be in-serviced on the requirem		
	Administrator and T	The Maintenance Director			not to prop doors open (see		
	during the exit conf				attachment A and A1).		
	Č	•			'		
	3.1-19(b)						
	(-)				To monitor the corrective action	nns	
					and ensure the deficient pract		
					will not recur, the ADM /Design		
					will complete the QA Tool title		
					Annual Survey 05/27/25 Track		
					(Attachment C). This tool will be		
					completed daily (5 days/week)		
					2 weeks, then weekly for 6 we		
					then monthly for 4 months, an		
					quarterly thereafter and will be	;	
					reviewed in one year by the		
					Quality Assurance (QA) team	to	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/27/2025		
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(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)	TE	(X5) COMPLETION DATE	
					determine the frequency of the audit. Any concerns will be addressed immediately and ha Quality Assurance and Quality Improvement Action Plan completed. The action plan wi reviewed at the monthly QAPI meeting with changes made a appropriate.	ave a / II be		
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or	Ramp Width						
	failed to meet the corridors in Buildin 19.2.3.4(5). LSC 1 corridor width is at the required width furniture, provided conditions are met: (a) the fixed furniture floor or to the wall. (b) the fixed furniture unobstructed corridexcept as permitted.	or width to less than six feet,	K 0	232	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. The furniture was immediately affixed to the floor on all three units. All residents have the potentia be affected by the same defici practice. To ensure that the deficient	so ays ,	06/27/2025	
	of the corridor.	22 is located only on one side			practice does not recur and to			

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(d) the fixed furniture is grouped such that each

grouping does not exceed an area of 50 square

(e) the fixed furniture groupings addressed in

(f) the fixed furniture is located so as to not

obstruct access to building service and fire

are protected by an electrically supervised

distance of at least 10 feet.

protection equipment.

19.2.3.4(5) (d) are separated from each other by a

(g) corridors throughout the smoke compartment

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monitor the corrective actions and

Annual Survey 05/27/25 Tracker 1

completed daily (5 days/week) for

2 weeks, then weekly for 6 weeks,

then monthly for 4 months, and

quarterly thereafter and will be

reviewed in one year by the

(Attachment C). This tool will be

ensure the deficient practice will not recur, the ADM /Designee will

complete the QA Tool titled

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/27/2025	
	PROVIDER OR SUPPLIER S MERRY MANOR	200 267	ADDRESS, CITY, STATE, ZIP COD ITH ST ISPORT, IN 46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE		
	automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 50 residents in the front halls on the first, second, and third floors. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 between 12:16 p.m. and 1:30 p.m., at the end of the front hall corridors by the exit doors of the first, second, and third floors, chairs and benches were not affixed to the floor or to the wall when tested. Based on interviews at 12:16 p.m., 1:02 p.m., and 1:30 p.m., the Maintenance Director agreed chairs and benches were in the front hall exit corridors of the first, second, and third floors and were not securely attached to the floor or wall. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and ha Quality Assurance and Quality Improvement Action Plan completed. The action plan wi reviewed at the monthly QAPI meeting with changes made a appropriate. All systemic changes will be completed by 06/27/25	ave a	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits				
	Based on observation and interview, the facility failed to ensure 1 of 12 exit discharges in Building One were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice	K 0271	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first.	so	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155235		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 05/27/2025		
	PROVIDER OR SUPPLIED S MERRY MANOR		200 26	ADDRESS, CITY, STATE, ZIP COD BTH ST NSPORT, IN 46947		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DESCRIPTION	ID PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	could affect 50 resi #3 from the first, so Findings include: Based on observati Director and the Ad 12:14 p.m., the exit concrete walkway Near the exit door, holes, and a sidewa tripping hazard. Al walkway was unev between two pieces hazard. Based on in Maintenance Direc unlevel walking su tripping hazard. The findings were Administrator and	dents that would use exit door econd, and third floors. on with the Maintenance diministrator on 05/27/25 at a discharge from door #3 had a reading to the common way. The walkway was uneven, had lk patch pulled away causing a reading to the parking lot, the ren and had a 1-inch drop reference at 12:14 p.m., the tor agreed the walkway had reface which could cause a reviewed with the The Maintenance Director ference at 3:10 p.m.	TAG	A sign was immediately plather ramp explaining that it we mergency use only. A boat placed between the pavemeramp as a temporary way of leveling the surface. All residents have the poter be affected by the same depractice. Currently no other discharges have uneven was surfaces. To ensure that the deficient practice does not recur the will be leveled off by 06/27/2 (Attachment K). To monitor the corrective as and ensure the deficient prawill not recur, the ADM /Deswill complete the QA Tool til Annual Survey 05/27/25 Training the prayers are the deficient prayers.	ced on vas for rd was ent and of ficient exit alking cramp 25.	
				(Attachment C). This tool w completed daily (5 days/we 2 weeks, then weekly for 6 then monthly for 4 months, quarterly thereafter and will reviewed in one year by the Quality Assurance (QA) tea determine the frequency of audit. Any concerns will be addressed immediately and Quality Assurance and Quality Assurance and Quality Assurance and Quality Assurance and Qualimprovement Action Plan completed. The action plan reviewed at the monthly QA meeting with changes made appropriate.	ill be ek) for weeks, and be e im to the I have a ality will be	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155235 B. WING 05/27/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 26TH ST MILLER'S MERRY MANOR LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0291 **NFPA 101** SS=C **Emergency Lighting** Bldg. 01 06/27/2025 Based on records review and interview, the facility K 0291 It is the policy of Miller's Merry failed to maintain itemized records of the Manor to operate in a fashion so inspections and tests for 10 of 10 battery backup the safety of the residents always lights in Building One. Section 7.9.3.1.1 (1) comes first. requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a Maintenance supervisor itemized maximum of 5 weeks between tests, for not less each of the battery-operated lights than 30 seconds, (3) Functional testing shall be to help track testing. conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery All residents have the potential to powered and (5) Written records of visual be affected by the same deficient inspections and tests shall be kept by the owner practice. An audit was conducted for inspection by the authority having to see if any lights were not jurisdiction. This deficient practice affects all itemized and no issues were residents in Building One. noted. Findings include: To ensure that the deficient practice does not recur The Based on records review with the Maintenance Maintenance supervisor was Director and the Administrator on 05/27/25 at in-serviced on the requirements of 10:55 a.m., in the TELS system, the NFPA 7.9.3.1.1 (Attachment F). battery-operated lights in Building One were tested monthly and annually but did not include To monitor the corrective actions an itemized list to show that each emergency light and ensure the deficient practice in the facility was tested. Based on an interview will not recur, the ADM /Designee at 10:55 a.m., the Maintenance Director stated the will complete the QA Tool titled monthly and annual battery-operated lights Annual Survey 05/27/25 Tracker 1 testing was checked off in the TELS system but (Attachment C). This tool will be was unable to list each light in the TELS system. completed daily (5 days/week) for

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3.1-19(b)

The findings were reviewed with the

during the exit conference at 3:10 p.m.

Administrator and The Maintenance Director

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2 weeks, then weekly for 6 weeks,

then monthly for 4 months, and

quarterly thereafter and will be

determine the frequency of the

reviewed in one year by the Quality Assurance (QA) team to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235			A. BUILDING B. WING	01	COMPLETED 05/27/2025
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
MILLER'S	MERRY MANOR		LOGA	NSPORT, IN 46947	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.	y ill be
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other				
	of 70 of 70 battery or resident rooms of Braccording to manufat 101 in 4.6.12.3 state obvious to the publishall be maintained. and Tests. Fire-warr maintained and tests manufacturer's publirequirements of Cha Inspection, testing, a shall satisfy the requipublished instruction affects all residents. Findings include: Based on observation Director and Admin 12:00 p.m. and 2:45 resident room contailarm. Based on recaccording to the smeared process.	cility failed to ensure cleaning operated smoke alarms in uilding One was conducted acturer's instructions. NFPA as existing life safety features are, if not required by the Code, NFPA 72, 29.10 Maintenance aring equipment shall be add in accordance with the aished instructions and per the apter 14. NFPA 72, 14.2.1.1.1 and maintenance programs arirements of this Code and poment manufacturer's ans. This deficient practice	K 0300	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. Immediate action to correct: A battery-operated smoke alarm were taken down and cleaned according to manufacturer's instructions. All residents have the potential be affected by the same deficit practice. To ensure that the deficient practice does not recur the environmental services directed was in-serviced on the prevent monthly preventative maintenance procedure and a tool was developed to track monthly cleaning of each smoke detect (Attachment G and L).	aso vays All as d al to ient or otative ance

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 05/27/2025	
	PROVIDER OR SUPPLIER		200 26	ADDRESS, CITY, STATE, ZIP COD STH ST NSPORT, IN 46947	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Smoke Detector tes itemized list indicat battery-operated sm but did not indicate monthly. Based on a Maintenance Direct cleaned if the alarm cleaned monthly accinstructions. The findings were r	The Maintenance Director		and ensure the deficient practive will not recur, the ADM /Design will complete the QA Tool title Annual Survey 05/27/25 Trace (Attachment C). This tool will completed daily (5 days/weel 2 weeks, then weekly for 6 when monthly for 4 months, an quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wereviewed at the monthly QAP meeting with changes made appropriate.	gnee ed cker 1 be k) for eeks, nd be n to ne to ne vill be
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				
7.39. 01	failed to ensure staf the UL 300 hood sy 96, 11.1.4 states ins operating the fire ex posted conspicuous reviewed with empl deficient practice co	on and interview, the facility If were instructed in the use of stem in 1 of 1 Kitchens. NFPA tructions for manually tringuishing system shall be ly in the kitchen and shall be oyees by management. This build affect staff in the kitchen the first floor dining room.	K 0324	It is the policy of Miller's Merr Manor to operate in a fashion the safety of the residents alv comes first. The cooks present at the time the survey were immediately in-serviced on the suppressic system pull station activation H and A2).	n so ways e of
	Based on observation	on with the Maintenance ministrator on 05/27/25 at hen was provided with a UL 300		All residents have the potenti be affected by the same defic practice.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155235	B. WING		05/27/2025
	PROVIDER OR SUPPLIER S MERRY MANOR SUMMARY	STATEMENT OF DEFICIENCIE	200 26	ADDRESS, CITY, STATE, ZIP COD STH ST NSPORT, IN 46947	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE
	posted instructions. p.m., two Cooks we there was a grease f how you would acti system. The Cooks gas and grab a fire of identify the location pull station activation acknowledged the Cooking will need to be procedures for extin cooking equipment.	eviewed with the The Maintenance Director		To ensure that the deficient practice does not recur all die staff will be in-serviced on the dietary Fire procedure (Attachment A and A2). To monitor the corrective actic and ensure the deficient pract will not recur, the ADM /Desig will complete the QA Tool title Annual Survey 05/27/25 Track (Attachment C). This tool will completed daily (5 days/week 2 weeks, then weekly for 6 we then monthly for 4 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and how Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.	ons tice inee to ker 1 be c) for eeks, id e to e ave a y ill be
K 0353 SS=E Bldg. 01		- Maintenance and Testing	K 0353	It is the policy of Miller's Merry	y 06/27/2025
	failed to ensure 5 of kitchen and 1 of 1 s riser room were not material, or corrode	F 10 sprinkler heads in the prinkler heads in the north loaded, covered with foreign d in accordance with LSC 9.7.5. tion, at 5.2.1.1.1 sprinklers shall	IX 0333	Manor to operate in a fashion the safety of the residents alw comes first.	so

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/27/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	not show signs of le	a LSC IDENTIFYING INFORMATION cakage; shall be free of		TAG	An outside vendor was contact		DATE
	corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall).				and came to replace the corro sprinkler heads on 06/12/25.	ded	
	Furthermore, at 5.2.	1.1.2 any sprinkler that shows following shall be replaced: (1)			All residents have the potential be affected by the same defici		
		ion (3) Physical Damage (4) glass bulb heat responsive			practice. An audit of all the sprinkler heads was conducted	d	
	` ′	g (6) Painting unless painted by acturer. This deficient practice			and no other corroded sprinkle heads were found.	er	
	could affect staff an smoke compartmen	d up to 30 residents in one t of Building One.			To ensure that the deficient		
	Findings include:				practice does not recur the environmental services directo be in-serviced on the quarterly		
		on with the Maintenance Iministrator on 05/27/25 at			preventative maintenance procedure (Attachment I).		
	heads were loaded of						
	covered with dirt ar				To monitor the corrective action and ensure the deficient praction	ice	
	cooktop were cover	_			will not recur, the DON /Design will complete the QA Tool titled	d	
	dishwasher showed	_			Annual Survey 05/27/25 Track (Attachment C). This tool will be	ре	
	the Maintenance Di	ew at 12:39 p.m. and 12:41 p.m., rector confirmed the			completed daily (5 days/week) 2 weeks, then weekly for 6 we	eks,	
	_	inkler heads showed signs of baded with dirt and grease.			then monthly for 4 months, and quarterly thereafter and will be		
	The findings were r	eviewed with the The Maintenance Director			reviewed in one year by the Quality Assurance (QA) team determine the frequency of the		
	during the exit conf				audit. Any concerns will be addressed immediately and ha		
	3.1-19(b)				Quality Assurance and Quality Improvement Action Plan		
					completed. The action plan wi reviewed at the monthly QAPI	I	
					meeting with changes made a appropriate.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 05/27/2025				
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation failed to ensure 1 of room corridor doors smoke and capable minutes. This defice residents on the section of	on and interview, the facility f 1 breakroom and 1 of 1 linen s could resist the passage of of resisting fire for at least 20 cient practice could affect 30 ond floor of Building One. on with the Maintenance laministrator on 05/27/25 at 1:09 the corridor doors to the closet and the breakroom each oles that went through the interview at 1:09 p.m. and 1:17 nee Director stated the holes tching of the door handles and s. eviewed with the The Maintenance Director	K 0363	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. The identified holes in the doc were immediately filled. All residents have the potentiabe affected by the same defic practice. An audit to find other effected doors was conducted any corridor doors with holes through them were filled. To ensure that the deficient practice does not recur all star were in-serviced on the need environmental services know there are holes in the corridor (Attachment A). To monitor the corrective actic and ensure the deficient pract will not recur, the ADM /Desig will complete the QA Tool title Annual Survey 05/27/25 Track (Attachment D). This tool will completed daily (5 days/week	of to let if s. ons tice innee ed ker 2 be		
				2 weeks, then weekly for 6 we then monthly for 4 months, an quarterly thereafter and will be	eeks,		

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reviewed in one year by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/27/2025			ETED		
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
MILLER'	S MERRY MANOR			200 26 ⁻ LOGAN	ISPORT, IN 46947		
(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		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1 -	DATE
					Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wi reviewed at the monthly QAPI meeting with changes made a appropriate.	ave a	
K 0372 SS=F Bldg. 01	Barrie Based on observation interview, the facility penetrations caused and/or conduits throwere protected to more of each smoke barris system, and 1 of 6 starting from an outside wall floor to floor. LSC barriers to be constructed barriers to be constructed barriers to be section 8.5 and share resistive rating. LSC smoke barriers to be wall to an outside wall from a smoke barrier of a combination the penetrations for cab pipes, tubes, vents, accommodate electron and communication wall, floor, or floor as a smoke barrier, membrane of the ro	Iding Spaces - Smoke on, records review, and ty failed to ensure the by the passage of wires ough 4 of 6 smoke barrier walls taintain the smoke resistance er with a proper firestop smoke walls were continuous Il to an outside wall and from Section 19.3.7.5 requires smoke ructed in accordance with LSC Il have a minimum ½ hour fire C Section 8.5.2.1 requires e continuous from an outside vall, from a floor to floor, or er to a smoke barrier, or by use ereof. 8.5.6.2 requires eles, cable trays, conduits, wires, and similar items to rical, mechanical, plumbing, as systems that pass through a feciling assembly constructed or through the ceiling off/ceiling of a smoke barrier	K 0	372	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. The smoke barriers were identified and the holes were f with drywall mud meeting AST 814. All residents have the potential be affected by the same defici practice. To ensure that the deficient practice does not recur: The smoke barriers were identified the holes were filled with dryw mud meeting ASTM E 814. To monitor the corrective action	so ays illed IM E I to ent and all	06/27/2025
	assembly, shall be p	protected by a system or restricting the movement of			and ensure the deficient practi will not recur, the ADM /Design		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED		
		155235	B. WI	NG		05/27/2025		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
				200 261				
MILLER'S	S MERRY MANOR			LOGAN	ISPORT, IN 46947			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG					(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE		
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		states the fire resistance of			will complete the QA Tool titled			
		and building assemblies shall			Annual Survey 05/27/25 Track			
		cordance with test procedure			(Attachment D). This tool will b			
		E 119, Standard Test Methods			completed daily (5 days/week)			
		ilding Construction and			2 weeks, then weekly for 6 we			
		UL 263, Standard for Fire			then monthly for 4 months, and			
	_	onstruction and Materials;			quarterly thereafter and will be	:		
	other approved test	methods; or analytical			reviewed in one year by the			
	methods approved b	by the AHJ. The AHJ requires			Quality Assurance (QA) team	to		
	penetrations in smo	ke barriers to be sealed with a			determine the frequency of the)		
	firestop system or d	levice tested in accordance			audit. Any concerns will be			
	with ASTM E 814.	This deficient practice could			addressed immediately and ha	ave a		
	affect all residents i	-			Quality Assurance and Quality			
		8			Improvement Action Plan			
	Findings include:				completed. The action plan wil	ll he		
	i mamgs meraac.				reviewed at the monthly QAPI			
	Rased on records re	eview with the Maintenance			meeting with changes made a			
		lministrator on 05/27/25 at				5		
					appropriate.			
		45 p.m., the provided						
		or plan identified smoke						
	I -	08, 118, 214, 220, 314, and 320.						
		action prints were found to						
	1	e location of each smoke						
	barrier. Based on ob							
		for and the Administrator						
	between 1:45 p.m. a	and 2:30 p.m., the following						
	smoke walls by the	following rooms were						
	unprotected:							
	a.) Above the ceilin	g of the first-floor smoke wall						
	by room 108 contain	ned unsealed penetrations and						
	penetrations filled v	vith dry wall mud not meeting						
	ASTM E 814.	-						
		g of the first-floor smoke wall						
		ned unsealed penetrations and						
		with dry wall mud not meeting						
	ASTM E 814.	a., maa not meeting						
		g of the second-floor smoke						
		ontained unsealed penetrations						
	1	-						
	and penetrations fill	led with dry wall mud not	1					

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meeting ASTM E 814.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155235			· /	ILDING	nstruction 01	(X3) DATE COMPL 05/27 /	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL		(X5) COMPLETION DATE
K 0511	by room 320 contained to ASTM E 814. e.) The wall on the sidentified as a smoke the wall was only before an outside wall floor to floor. Based on interviews the Maintenance Di rooms 108, 118, 214 walls, contained unspenetrations filled was ASTM E 814, and the smoke wall not come an outside wall and the findings were readministrator an	eviewed with the The Maintenance Director erence at 3:10 p.m.					
SS=D Bldg. 01	failed to ensure 1 of interrupter (GFCI) i properly maintained shock. NFPA 70, N Ground-Fault Circu Personnel, states, gr for personnel shall b	on and interview, the facility I ground fault circuit In the lobby restroom was I for protection against electric IEC 2011 Edition at 210.8 It-Interrupter Protection for cound-fault circuit-interruption to provided as required in It practice could affect 1	K 0.	511	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents always comes first. Immediate action to correct: TI GFCI electric receptacle in the first-floor spa/ shower room was replaced. All residents have the potential be affected by the same deficient	so ays ne as	06/27/2025

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155235	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPLE 05/27/2	ETED	
	PROVIDER OR SUPPLIER S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Based on an observation with the Maintenance Director and the Administrator on 05/27/25 at 1:02 p.m., when the GFCI electric receptacle in the first-floor spa/shower room was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on an interview at 1:02 p.m., the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		practice. An audit was completed to ensure there were no other situations of GFCI receptacles breaking the electrical circuit witripped with no findings. To ensure that the deficient practice does not recur the Maintenance supervisor was in-serviced on NFPA 70, NEC 2011 at 210.8 (Attachment F) To monitor the corrective action and ensure the deficient pract will not recur, the ADM /Desig will complete the QA Tool title Annual Survey 05/27/25 Track (Attachment D). This tool will be completed daily (5 days/week 2 weeks, then weekly for 6 wee	ons ice nee d ker 2 pe) for eeks, d e		
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills					
Diag. 01	Based on record review and interview, the facility	K 0712	It is the policy of Miller's Merry	,	06/27/2025	

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/27/2025
	OF PROVIDER OR SUPPLIE		200 26	ADDRESS, CITY, STATE, ZIP COD ITH ST NSPORT, IN 46947	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	failed to conduct q	uarterly fire drills at unexpected g conditions on all shifts for 4 deficient practice affects all	TAG	Manor to operate in a fashion the safety of the residents alw comes first.	so
	Based on records red Director and the Ar 10:39 a.m., the foll drills at unexpected a. All second shift drills took place are b. All third shift (1 took place around 2 Based on an intervention of the Aries of the A	(2:00 p.m. to 10:00 p.m.) fire ound 2:00 p.m. 0:00 p.m. to 6:00 a.m.) fire drills		A fire drill was held at an unexpected time varying from previous drills. All residents have the potential be affected by the same deficipractice. To ensure that the deficient practice does not recur The Environmental Services Direct was in-serviced on the require to hold fire drill at unexpected times under varying conditions.	al to ient tor ement
		The Maintenance Director ference at 3:10 p.m.		(Attachment F.) To monitor the corrective actic and ensure the deficient pract will not recur, the ADM /Desig will complete the QA Tool title Annual Survey 05/27/25 (Attachment D). This tool will I completed daily (5 days/week 2 weeks, then weekly for 6 we then monthly for 4 months, an quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan will see the completed of the action plan will be action pla	ons tice nee d be) for eeks, d e to e ave a

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 2 01	(X3) DATE SURVEY COMPLETED 05/27/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Teviewed at the monthly QAPI		
				meeting with changes made as appropriate.		
K 0761 SS=E Bldg. 01		pection & Testing - Doors				
	interviews, the facinspection and testing doors were completed 19.1.1.4.1.1 commutations fire barriers require permitted only in completed by approved self-classical (See also Section 8 required to have a factor of the section of t	ons, records review, and lity failed to ensure the annual ng of 3 of 3 oxygen room fire ted in accordance of LSC unicating openings in dividing of by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, semblies and fire window or accompanying hardware, as, closing devices, anchorage, nee with the requirements of a for Fire Doors and Other as, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both overall condition of door 0, 5.2.4.2 states as a minimum,	K 0761	It is the policy of Miller's Merry Manor to operate in a fashion since the safety of the residents always comes first. Immediate action to correct: The fire doors were inspected and added to the annual calendar or inspection at the facility. All residents have the potential be affected by the same deficie practice. To ensure that the deficient practice does not recur all three oxygen room fire doors were added to the annual inspection schedule and the environmental services director was in-service on this requirement (Attachment F).	e f to nt	
	the following items (1) No open holes of either the door or fi (2) Glazing, vision	s shall be verified: or breaks exist in surfaces of		and ensure the deficient practic will not recur, the ADM /Designa will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be completed daily (5 days/week)	ee	

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(3) The door, frame, hinges, hardware, and

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2 weeks, then weekly for 6 weeks,

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	UILDING	onstruction 01	(X3) DATE COMPL 05/27 /	ETED
	PROVIDER OR SUPPLIER		200 261	ADDRESS, CITY, STATE, ZIP COD ITH ST ISPORT, IN 46947		
(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)	TE	(X5) COMPLETION DATE
	noncombustible thrand in working order damage. (4) No parts are misted in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open parts (7) If a coordinator closes before the active door when it is in the self-closing threat three smoke comparation and inspected to verify This deficient pract three smoke comparations include: Based on observation and the self-close include: Based on observation and the self-close include: Based on observation and the self-close include: Based on observation include inclu	eshold are secured, aligned, er with no visible signs of ssing or broken. I do not exceed clearances is 3.1.7. I device is operational; that is, apletely closes when operated position. It is installed, the inactive leaf stive leaf. I are operates and secures the ne closed position. I are items that interfere or are not installed on the door or are not installed on the door or are not installed on the door assembly ed that void the label. Edge seals, where required, are their presence and integrity. I ice could affect 50 residents in artments. I ons with the Maintenance deministrator on 05/27/25 I and 1:10 p.m., the oxygen cloors on the first, second, and the das a 45-minute fire door. I wiew at 10:04 a.m., the ne annual fire door inspections ridor fire door assemblies were here oxygen transfilling room could be a sinspected. Based on the first, the Maintenance there oxygen-transfilling room inspected.		then monthly for 4 months, an quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.	to e ave a /	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		(X2) MULTIPLE (A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
		The Maintenance Director			5.112		
K 0920 SS=E	3.1-19(b) NFPA 101 Electrical Equipme	ent - Power Cords and					
Bldg. 01			K 0920	It is the policy of Miller's Merr Manor to operate in a fashior the safety of the residents alw comes first. The power strips were immediated away. All residents have the potentiate affected by the same deficient practice. To ensure that the deficient practice does not recur all stawere in-serviced on the power policy (Attachment B).	n so ways diately dal to cient		
	Director and the Ad 12:53 p.m., in the bestrip in use that did certification. Based the Maintenance Di in the beauty shop certification and rer	rvation with the Maintenance ministrator on 05/27/25 at eauty shop there was a power not contain an UL rating or on an interview at 12:53 p.m., rector agreed the power strip lid not have a UL rating or noved the power strip.		To monitor the corrective active and ensure the deficient practive will not recur, the ADM /Design will complete the QA Tool title Annual Survey 05/27/25 (Attachment D). This tool will completed daily (5 days/weel 2 weeks, then weekly for 6 weeks, then monthly for 4 months, and guaraterly thereafter and will be greaterly thereafter and will be a supported to the correction of the control of the correction and will be a supported to the correction and th	etice gnee ed be k) for eeks, nd		
	Director and the Ad p.m., a water chiller (high power draw e	ministrator on 05/27/25 at 1:19 with a cooling compressor quipment) was plugged into a reak room. Based on an		quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be	ı to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235		î î	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/27/2025	
	PROVIDER OR SUPPLIER		200 2	ET ADDRESS, CITY, STATE, ZIP CO 26TH ST ANSPORT, IN 46947	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
	agreed that high por plugged into a powe strip. The findings were r	The Maintenance Director		addressed immediately Quality Assurance and of Improvement Action Plate completed. The action previewed at the monthly meeting with changes mappropriate.	Quality an olan will be [,] QAPI	
K 0927 SS=F Bldg. 01	Based on observation failed to ensure 3 of storage/transfer root provided with signst transfilling is occur. 99 11.5.2.3.1(3) starts signs indicating that that smoking is the permitted. This definites in three smokings include: Based on observation	ms in Building One were indicating when oxygen ring and not occurring. NFPA tes, the area is posted with t trans-filling is occurring and immediate area is not cient practice could affect 50	K 0927	It is the policy of Miller's Manor to operate in a fathe safety of the resider comes first. Immediate action to conto indicate when oxyger occurring were ordered oxygen rooms. These siplaced on the door on 0 All residents have the pube affected by the same practice.	rect: Signs in filling is for all three igns were 6/13/25.	06/27/2025
	between 12:23 p.m. transfilling room do third floors did not when oxygen transf occurring. The door signs stating oxyger the sign did not indiwas not occurring. p.m., 1:10 p.m., and Director stated the sign did not individually not not occurring.	and 1:30 p.m., the oxygen fors on the first, second, and contain a proper sign stating filling is occurring and not as had permanent attached in transfilling is occurring but deate when oxygen transfilling Based on an interview at 12:23 in 1:30 p.m., the Maintenance		To ensure that the defice practice does not recurbe in-serviced on the trained storage of oxygen processes (Attachment J). To monitor the corrective and ensure the deficient will not recur, the DON A	all staff will ansferring procedure e actions t practice	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/27/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE OPRIATE COMPLETION DATE		
	indicate when trans The findings were r	The Maintenance Director		will complete the QA Tool Annual Survey 05/27/25 (Attachment D). This tool completed daily (5 days/w 2 weeks, then weekly for then monthly for 4 months quarterly thereafter and w reviewed in one year by the Quality Assurance (QA) to determine the frequency caudit. Any concerns will be addressed immediately ar Quality Assurance and Quality Assurance a	will be veek) for 6 weeks, 6, and ill be ne eam to of the e nd have a uality In will be		
K 0000							
Bldg. 02	Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/27 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety 0 Manor was found n Requirements for Pa Medicare/Medicaid Life Safety from Fire	00140 55235 66960 Code survey, Miller's Merry ot in compliance with	K 0000	On May 27, 2025, an ann safety code survey was conducted. A plan of corre was formally implemented receipt of the CMS Form 2 Attached is the plan of column all pertinent attachments, facility representative's sign page one of the 2567. review the submitted plan correction to the cited defiand contact us should you any questions following the of the plan of correction.	ection I upon 2567. rrection, and the gnature Please of iciencies u have		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155235			A. BUILDING B. WING	02	COMPLETED 05/27/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947			
(X4) ID PREFIX	(EACH DEFICIEN	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)		
TAG	Life Safety Code (L Care Occupancies a		TAG	BEIGHACH	DATE	
	different construction existing health care building with a part to be of Type II (11 sprinklered. Buildin addition one story building to be of Type V (111) con The buildings were wall.	s of two buildings with on types. Building One, the and memory care three story ial basement was determined 1) construction and fully g Two, the new therapy uilding was determined to be astruction and fully sprinklered. separated by a two-hour fire				
	corridors. The facili had a census of 87 a All areas where the	_				
K 0211 SS=F Bldg. 02	failed to maintain the of 4 exits egresses in with LSC section 7. Assemblies which seassemblies shall be provided that all of (1) The door leaf is side without special (2) The force that, we device in the direction	on and interview, the facility the means of egress through 1 in Building Two in accordance 2.1.14 Horizontal-Sliding Door tates, horizontal-sliding door permitted in means of egress, the following criteria are met: readily operable from either knowledge or effort. When applied to the operating on of egress, is required to f is not more than 15 lbf (67	K 0211	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents always comes first. The doors were immediately worked on and the breakaway feature is operational for both of doors in this building are no working.	so ays sets	

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	N). (3) The force requires the direction of tray. N) to set the leaf in lbf (67 N) to close to minimum required (4) The door leaf is more than 50 lbf (22) (1100 N) is applied adjacent to the oper opening is an existing access door assembly (5) The door assembly rotection rating, if self-closing or autors smoke detection in installed in accordate This deficient pract Building Two. Findings include: Based on observation Director and the Additional action of the properties of doors and of sets of doors did oppush breakaway fear doors, the doors did interview at 10:39 and agreed the exterior when the breakaway. The findings were referred to the doors and the properties of the doors did interview at 10:39 and agreed the exterior when the breakaway.	ed to operate the door leaf in el is not more than 30 lbf (133 motion and is not more than 15 he leaf or open it to the width. operable using a force of not 22 N) when a force of 250 lbf perpendicularly to the leaf ating device, unless the door ng horizontal-sliding exit ly obly complies with the fire required, and, where rated, is matic closing by means of accordance with 7.2.1.8 and is nee with NFPA80. Ice affects all residents in the east exit had two sets of oor assemblies, one set of one set of exterior doors. Both en automatically but when the ture was tested on the exterior not open. Based on an a.m., the Maintenance Director doors would not swing open by feature was tested.		All residents have the potenti be affected by the same deficipractice. To ensure that the deficient practice does not recur the maintenance supervisor was in-serviced on NFPA chapter specifically on the means of egress section (Attachment F To monitor the corrective acti and ensure the deficient practification will not recur, the ADM /Desigwill complete the QA Tool title Annual Survey 05/27/25 Tractic (Attachment E). This tool will completed daily (5 days/week 2 weeks, then weekly for 6 withen monthly for 4 months, an quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Qualit Improvement Action Plan completed. The action plan wereviewed at the monthly QAP meeting with changes made appropriate.	al to cient 7 7 ons tice gnee ed ker 3 be k) for eeks, nd e to e ave a y rill be I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 05/27/2025 155235 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 26TH ST MILLER'S MERRY MANOR LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0291 **NFPA 101** SS=C **Emergency Lighting** Bldg. 02 Based on records review and interview, the facility K 0291 06/27/2025 It is the policy of Miller's Merry failed to maintain itemized records of the Manor to operate in a fashion so inspections and tests for 4 of 4 battery backup the safety of the residents always lights in Building Two. Section 7.9.3.1.1 (1) comes first. requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a Maintenance supervisor itemized maximum of 5 weeks between tests, for not less each of the battery-operated lights than 30 seconds, (3) Functional testing shall be to help track testing. conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery All residents have the potential to powered and (5) Written records of visual be affected by the same deficient inspections and tests shall be kept by the owner practice. An audit was conducted for inspection by the authority having to see if any lights were not jurisdiction. This deficient practice affects all itemized and no issues were residents in Building One. noted. Findings include: To ensure that the deficient practice does not recur The Based on records review with the Maintenance Maintenance supervisor was Director and the Administrator on 05/27/25 at in-serviced on the requirements of 10:55 a.m., in the TELS system, the NFPA 7.9.3.1.1 (Attachment F). battery-operated lights in Building Two were tested monthly and annually but did not contain To monitor the corrective actions an itemized list to show that each emergency light and ensure the deficient practice in the facility was tested. Based on an interview will not recur, the ADM /Designee at 10:55 a.m., the Maintenance Director stated the will complete the QA Tool titled monthly and annual battery-operated lights Annual Survey 05/27/25 Tracker 1 testing was checked off in the TELS system but (Attachment C). This tool will be was unable to list each light in the TELS system. completed daily (5 days/week) for 2 weeks, then weekly for 6 weeks, The findings were reviewed with the then monthly for 4 months, and Administrator and The Maintenance Director quarterly thereafter and will be during the exit conference at 3:10 p.m. reviewed in one year by the Quality Assurance (QA) team to 3.1-19(b) determine the frequency of the audit. Any concerns will be addressed immediately and have a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155235 B. WING 05/27/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 26TH ST MILLER'S MERRY MANOR LOGANSPORT. IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 02 Based on observation and interview, the facility K 0353 It is the policy of Miller's Merry 06/27/2025 failed to ensure 2 of 2 sprinkler system gauges in Manor to operate in a fashion so Building Two were replaced every 5 years or the safety of the residents always documented as tested every 5 years by comes first. comparison with a calibrated gauge. NFPA 25, The identified gauges were Standard for the Inspection, Testing, and replaced by an outside vendor. Maintenance of Water-Based Fire Protection All residents have the potential to Systems, 2011 Edition, Section 5.3.2.1 states be affected by the same deficient gauges shall be replaced every 5 years or tested practice. Currently the facility has every 5 years by comparison with a calibrated no other sprinkler system gauges gauge. Gauges not accurate to within 3 percent of that are needing recalibrated or the full scale shall be recalibrated or replaced. replaced. This deficient practice affects all residents in To ensue the deficient practice Building Two. will not recur the Maintenance supervisor was in-serviced on Findings include: NFPA 25, Standard for the Inspection, Testing, and Based on observations with the Maintenance Maintenance of Water-Based Fire Director and the Administrator on 05/27/25 at Protection Systems. 11:48 a.m., the facility's sprinkler system in Building Two had two pressure gauges with a To monitor the corrective actions, manufactures date of 2019, and no recalibration the ADM /Designee will complete date information was affixed to the sprinkler the QA Tool titled Annual Survey system gauges. Based on interview at 11:48 p.m., 05/27/25 Tracker 3 (Attachment the Maintenance Director agreed the two gauges E). This tool will be completed were older than five years and have not been daily (5 days/week) for 2 weeks, recalibrated. then weekly for 6 weeks, then monthly for 4 months, and

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The findings were reviewed with the

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quarterly thereafter and will be

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155235	(X2) MULTIPLE (A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 05/27/2025			
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Administrator and I during the exit conf 3.1-19(b)	The Maintenance Director ference at 3:10 p.m.		reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wi reviewed at the monthly QAPI meeting with changes made a appropriate.	e ave a / Il be			
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on all shifts for 4 of 4 quarters. This deficient practice affects all residents.		K 0712	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first.	hion so			
	Director and the Ad 10:39 a.m., the follodrills at unexpected a. All second shift (drills took place arob. All third shift (10 took place around 5 Based on an interview Maintenance Direct agreed fire drills for unexpected times.	2:00 p.m. to 10:00 p.m.) fire und 2:00 p.m. to 6:00 a.m.) fire drills :00 a.m. ew at 10:39 a.m., the or and the Administrator two shifts were not held at eviewed with the The Maintenance Director		A fire drill was held at an unexpected time varying from previous drills. All residents have the potential be affected by the same deficing practice. To ensure that the deficient practice does not recur The Environmental Services Direct was in-serviced on the require to hold fire drill at unexpected times under varying conditions (Attachment F.) To monitor the corrective action and ensure the deficient practice.	al to ient tor ement			

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ίΤΕ	(X5) COMPLETION DATE		
K 0920	3.1-19(b) 3.1-51(c)				will not recur, the ADM /Desig will complete the QA Tool title Annual Survey 05/27/25 (Attachment D). This tool will I completed daily (5 days/week 2 weeks, then weekly for 6 we then monthly for 4 months, an quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team determine the frequency of the audit. Any concerns will be addressed immediately and he Quality Assurance and Quality Improvement Action Plan completed. The action plan wireviewed at the monthly QAPI meeting with changes made a appropriate.	be) for eeks, id e to e		
SS=E Bldg. 02	Electrical Equipment Extens Based on observation failed to ensure 3 compatient care location of 1363A or 60601 affect 8 residents in Findings include: Based on observation Director and the A 11:57 a.m., three putherapy gym where that did not meet 1 interview at 11:57 agreed three power	on and interview, the facility of 4 flexible cord power strips in ons met the required UL rating -1. This deficient practice can on the therapy gym. ons with the Maintenance deministrator on 05/27/25 at ower strips were in use in the expression resident care was provided 363A or 60601-1. Based on an a.m., the Maintenance Director extrips were in use in a resident of meet 1363A or 60601-1.	K 09	20	It is the policy of Miller's Merry Manor to operate in a fashion the safety of the residents alw comes first. The power strips were immed taken away. All residents have the potentiabe affected by the same deficipractice. To ensure that the deficient practice does not recur all starwere in-serviced on the power	so vays iately al to ient	06/27/2025	

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COMPLETED 05/27/2025					
STREET ADDRESS, CITY, STATE, ZIP COD 200 26TH ST LOGANSPORT, IN 46947					
of CORRECTION COMPLETION DATE IN CY) TO THE APPROPRIATE NCY) IN B). Trective actions efficient practice DON /Designee QA Tool titled 5/27/25 This tool will be 5 days/week) for ekly for 6 weeks, 4 months, and er and will be ear by the e (QA) team to quency of the ns will be diately and have a er and Quality on Plan ction plan will be nonthly QAPI nges made as					

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