STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING -- B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 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: 05/27/25 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 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 a capacity of 127 and had a census of 87 at the time of this survey. Quality Review completed on 06/02/25	E 0000	On May 27, 2025, an annual life safety code survey was conducted. A plan of correction was formally implemented upon receipt of the CMS Form 2567. Attached is the plan of correction, all pertinent attachments, and the facility representative's signature on page one of the 2567. Please review the submitted plan of correction to the cited deficiencies and contact us should you have any questions following the review of the plan of correction.	
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: 05/27/25 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in	K 0000	On May 27, 2025, an annual life safety code survey was conducted. A plan of correction was formally implemented upon receipt of the CMS Form 2567. Attached is the plan of correction, all pertinent attachments, and the facility representative's signature on page one of the 2567. Please review the submitted plan of correction to the cited deficiencies and contact us should you have any questions following the review of the plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zackary Freel	Administrator	06/13/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 consists of two buildings with different construction types. Building One, the existing health care and memory care three story building with a partial basement was determined to be of Type II (111) construction and fully sprinklered. Building Two, the new therapy addition one story building was determined to be of Type V (111) construction and fully sprinklered. The buildings were separated by a two-hour fire wall. Building One has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in the sleeping rooms. The facility has a capacity of 127 and had a census of 87 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/02/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 3 exit discharges doors in the kitchen had a releasing device that did not require use of special knowledge or extra effort in accordance with 7.2.1.4 Swinging-Type Door Assembly Requirement. 7.2.1.4.1 (3) (d) states door leaves or grilles shall be operable from within	K 0211	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The doorknob was immediately replaced with one that does not take extra effort or special	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the space without the use of any special knowledge or effort. This deficient practice could affect staff in the kitchen using the back exit door during an emergency. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/27/25 at 12:42 a.m., when the back exit door in the kitchen was tested by the surveyor, the door would not open. It was discovered the doorknob had a turn lock on the knob but did not unlock when the knob was twisted and the lock had to be manually turned. This condition requires extra effort to open the door and could delay exiting the kitchen during an emergency. Based on an interview at 12:42 a.m., the Maintenance director agreed in order to open the exit door, it took extra effort or special knowledge to unlock and turn the door handle to exit the kitchen. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		knowledge to unlock the door handle and exit the kitchen. All residents have the potential to be affected by this deficient practice. All exit doors have the potential to be affected by the same deficient practice. A full audit of all the exit doors was conducted. No other exit doors were affected. To ensure that the deficient practice does not recur all staff will be in-serviced on the NFPA regulations (Attachment A and A1). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0223 SS=E	NFPA 101 Doors with Self-Closing Devices			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 2 Hazardous storage room corridor doors on the second floor was not obstructed from closing. This deficient practice affects 25 residents in one smoke compartment. Findings include: Based on an observation with the Maintenance Director and the Administrator on 05/27/25 at 12:15 p.m., the second floor housekeeping room contained over 10 boxes of combustible supplies, flammable aerosol cans, and was greater than 50 square feet making this a hazardous area. The door to the room was self-closing but the door was held open by a chain wrapped around the door handle. Based on interview at 12:15 p.m., the Maintenance Director agreed the housekeeping room contained combustible storage, was larger than 50 square feet, and the corridor door to the room was held open with a chain. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)	K 0223	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The chain holding the door open was immediately taken away and the door was closed. All residents have the potential to be affected by this deficient practice. All hazardous storage areas have the potential to be affected by the same deficient practice. A full audit of all the hazardous storage areas was conducted. No other hazardous storage areas were affected. To ensure that the deficient practice does not recur all staff will be in-serviced on the requirement not to prop doors open (see attachment A and A1). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet the clear width requirement for 3 of 6 corridors in Building One or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised	K 0232	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The furniture was immediately affixed to the floor on all three units. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur and to monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(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 to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. All systemic changes will be completed by 06/27/25	
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 so the safety of the residents always comes first.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could affect 50 residents that would use exit door #3 from the first, second, and third floors. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 12:14 p.m., the exit discharge from door #3 had a concrete walkway leading to the common way. Near the exit door, the walkway was uneven, had holes, and a sidewalk patch pulled away causing a tripping hazard. Also near the parking lot, the walkway was uneven and had a 1-inch drop between two pieces of concrete causing a tripping hazard. Based on interview at 12:14 p.m., the Maintenance Director agreed the walkway had unlevel walking surface which could cause a tripping hazard. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		A sign was immediately placed on the ramp explaining that it was for emergency use only. A board was placed between the pavement and ramp as a temporary way of leveling the surface. All residents have the potential to be affected by the same deficient practice. Currently no other exit discharges have uneven walking surfaces. To ensure that the deficient practice does not recur the ramp will be leveled off by 06/27/25. (Attachment K). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 10 of 10 battery backup lights in Building One. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice affects all residents in Building One. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/27/25 at 10:55 a.m., in the TELS system, the battery-operated lights in Building One were tested monthly and annually but did not include an itemized list to show that each emergency light in the facility was tested. Based on an interview at 10:55 a.m., the Maintenance Director stated the monthly and annual battery-operated lights testing was checked off in the TELS system but was unable to list each light in the TELS system. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)	K 0291	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. Maintenance supervisor itemized each of the battery-operated lights to help track testing. All residents have the potential to be affected by the same deficient practice. An audit was conducted to see if any lights were not itemized and no issues were noted. To ensure that the deficient practice does not recur The Maintenance supervisor was in-serviced on the requirements of NFPA 7.9.3.1.1 (Attachment F). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			audit. Any concerns will be addressed immediately and have a 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 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Based on records review, interview, and observations, the facility failed to ensure cleaning of 70 of 70 battery operated smoke alarms in resident rooms of Building One was conducted according to manufacturer's instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice affects all residents in Building One. Findings include: Based on observations with the Maintenance Director and Administrator on 05/27/25 between 12:00 p.m. and 2:45 p.m., in Building One each resident room contained a battery-operated smoke alarm. Based on records review at 10:58 a.m., according to the smoke alarm manufacturer's instructions, "the smoke alarms should be tested	K 0300	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. Immediate action to correct: All battery-operated smoke alarms were taken down and cleaned according to manufacturer's instructions. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur the environmental services director was in-serviced on the preventative monthly preventative maintenance procedure and a tool was developed to track monthly cleaning of each smoke detector (Attachment G and L). To monitor the corrective actions	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weekly and cleaned monthly." Upon review of the Smoke Detector testing documentation, the itemized list indicated the resident room's battery-operated smoke alarms are tested weekly, but did not indicate if the alarms were cleaned monthly. Based on an interview at 10:58 a.m., the Maintenance Director stated the alarms are only cleaned if the alarms look dirty and are not cleaned monthly according to manufacturer's instructions. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the first floor dining room. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 12:40 p.m., the kitchen was provided with a UL 300	K 0324	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The cooks present at the time of the survey were immediately in-serviced on the suppression system pull station activation (Att. H and A2). All residents have the potential to be affected by the same deficient practice.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hood system and a K-class fire extinguisher with posted instructions. Based on interviews at 12:47 p.m., two Cooks were asked what would you do if there was a grease fire underneath the hood and how you would activate the hood suppression system. The Cooks stated they would turn off the gas and grab a fire extinguisher and could not identify the location of the suppression system pull station activation. The Maintenance Director acknowledged the Cooks response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		To ensure that the deficient practice does not recur all dietary staff will be in-serviced on the dietary Fire procedure (Attachment A and A2). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 5 of 10 sprinkler heads in the kitchen and 1 of 1 sprinkler heads in the north riser room were not loaded, covered with foreign material, or corroded in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall	K 0353	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 30 residents in one smoke compartment of Building One. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 12:39 p.m. and 12:41 p.m., the following sprinkler heads were loaded or corroded: a. In the north riser room a sprinkler head was covered with dirt and lint. b. In the kitchen the two sprinkler heads by the cooktop were covered with grease. c. In the kitchen the three sprinkler heads by the dishwasher showed signs of corrosion. Based on an interview at 12:39 p.m. and 12:41 p.m., the Maintenance Director confirmed the aforementioned sprinkler heads showed signs of corrosion or were loaded with dirt and grease. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		An outside vendor was contacted and came to replace the corroded sprinkler heads on 06/12/25. All residents have the potential to be affected by the same deficient practice. An audit of all the sprinkler heads was conducted and no other corroded sprinkler heads were found. To ensure that the deficient practice does not recur the environmental services director will be in-serviced on the quarterly preventative maintenance procedure (Attachment I). To monitor the corrective actions and ensure the deficient practice will not recur, the DON /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 breakroom and 1 of 1 linen room corridor doors could resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 30 residents on the second floor of Building One. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 1:09 p.m. and 1:17 p.m., the corridor doors to the second floor linen closet and the breakroom each had two 1/8-inch holes that went through the doors. Based on an interview at 1:09 p.m. and 1:17 p.m., the Maintenance Director stated the holes were due to the switching of the door handles and not sealing the holes. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)	K 0363	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The identified holes in the doors were immediately filled. All residents have the potential to be affected by the same deficient practice. An audit to find other effected doors was conducted and any corridor doors with holes through them were filled. To ensure that the deficient practice does not recur all staff were in-serviced on the need to let environmental services know if there are holes in the corridors. (Attachment A). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 2 (Attachment D). This tool will be 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	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation, records review, and interview, the facility failed to ensure the penetrations caused by the passage of wires and/or conduits through 4 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier with a proper firestop system, and 1 of 6 smoke walls were continuous from an outside wall to an outside wall and from floor to floor. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of	K 0372	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The smoke barriers were identified and the holes were filled with drywall mud meeting ASTM E 814. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur: The smoke barriers were identified and the holes were filled with drywall mud meeting ASTM E 814. To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	smoke. LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affect all residents in Building One Findings include: Based on records review with the Maintenance Director and the Administrator on 05/27/25 at 11:14 a.m. and at 2:45 p.m., the provided evacuation rout floor plan identified smoke barriers by rooms 108, 118, 214, 220, 314, and 320. No building/construction prints were found to correctly identify the location of each smoke barrier. Based on observation with the Maintenance Director and the Administrator between 1:45 p.m. and 2:30 p.m., the following smoke walls by the following rooms were unprotected: a.) Above the ceiling of the first-floor smoke wall by room 108 contained unsealed penetrations and penetrations filled with dry wall mud not meeting ASTM E 814. b.) Above the ceiling of the first-floor smoke wall by room 118 contained unsealed penetrations and penetrations filled with dry wall mud not meeting ASTM E 814. c.) Above the ceiling of the second-floor smoke wall by room 214 contained unsealed penetrations and penetrations filled with dry wall mud not meeting ASTM E 814.		will complete the QA Tool titled Annual Survey 05/27/25 Tracker 2 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	d.) Above the ceiling of the third-floor smoke wall by room 320 contained unsealed penetrations and penetrations filled with dry wall mud not meeting ASTM E 814. e.) The wall on the second floor by 220 was identified as a smoke barrier, but when inspected the wall was only ½ complete and not continuous from an outside wall to an outside wall and from floor to floor. Based on interviews at 11:14 a.m. and at 2:45 p.m., the Maintenance Director agreed the walls by rooms 108, 118, 214, 314, and 320 were smoke walls, contained unsealed penetrations, contained penetrations filled with dry wall mud not meeting ASTM E 814, and the wall by room 220 was a smoke wall not continuous from an outside wall to an outside wall and from floor to floor. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the lobby restroom was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 1 resident when using the first floor spa. Findings include:	K 0511	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. . Immediate action to correct: The GFCI electric receptacle in the first-floor spa/ shower room was replaced. All residents have the potential to be affected by the same deficient	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(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 not breaking the electrical circuit when tripped 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 actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 2 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility	K 0712	It is the policy of Miller's Merry	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/27/25 at 10:39 a.m., the following shifts did not have fire drills at unexpected times: a. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place around 2:00 p.m. b. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place around 5:00 a.m. Based on an interview at 10:39 a.m., the Maintenance Director and the Administrator agreed fire drills for two shifts were not held at unexpected times. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b) 3.1-51(c)		Manor to operate in a fashion so the safety of the residents always comes first. A fire drill was held at an unexpected time varying from previous drills. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur The Environmental Services Director was in-serviced on the requirement to hold fire drill at unexpected times under varying conditions (Attachment F.) To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reviewed at the monthly QAPI meeting with changes made as appropriate.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observations, records review, and interviews, the facility failed to ensure the annual inspection and testing of 3 of 3 oxygen room fire doors 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 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 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, 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	K 0761	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. Immediate action to correct: The fire doors were inspected and added to the annual calendar of inspection at the facility. All residents have the potential to be affected by the same deficient 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-serviced on this requirement (Attachment F). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 6 weeks,	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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 50 residents in three smoke compartments. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/27/25 between 12:23 p.m. and 1:10 p.m., the oxygen transfilling rooms doors on the first, second, and third floors were rated as a 45-minute fire door. Based on records review at 10:04 a.m., the documentation of the annual fire door inspections listed ten cross-corridor fire door assemblies were inspected, but the three oxygen transfilling room fire doors were not listed as inspected. Based on an interview at 10:04 a.m., the Maintenance Director stated the three oxygen-transfilling room fire doors were not inspected. The findings were reviewed with the		then monthly for 4 months, and quarterly thereafter and will be reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens (#1.) Based on observation and interview, the facility failed to ensure 1 of 1 power strips in non-patient care rooms meet UL standards. This deficient practice affects three residents in the beauty shop. (#2.) Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 25 residents in one smoke compartment. Findings include: (#1.) Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 12:53 p.m., in the beauty shop there was a power strip in use that did not contain an UL rating or certification. Based on an interview at 12:53 p.m., the Maintenance Director agreed the power strip in the beauty shop did not have a UL rating or certification and removed the power strip. (#2.) Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 1:19 p.m., a water chiller with a cooling compressor (high power draw equipment) was plugged into a power strip in the break room. Based on an	K 0920	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The power strips were immediately taken away. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur all staff were in-serviced on the power strip policy (Attachment B). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview at 1:19 p.m., the Maintenance Director agreed that high power draw equipment was plugged into a power strip and removed the power strip. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		addressed immediately and have a 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 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 3 of 3 liquid oxygen storage/transfer rooms in Building One were provided with signs indicating when oxygen transfilling is occurring and not occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 50 residents in three smoke compartments. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/27/25 between 12:23 p.m. and 1:30 p.m., the oxygen transfilling room doors on the first, second, and third floors did not contain a proper sign stating when oxygen transfilling is occurring and not occurring. The doors had permanent attached signs stating oxygen transfilling is occurring but the sign did not indicate when oxygen transfilling was not occurring. Based on an interview at 12:23 p.m., 1:10 p.m., and 1:30 p.m., the Maintenance Director stated the signs attached to the transfilling room doors only stated oxygen	K 0927	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. Immediate action to correct: Signs to indicate when oxygen filling is occurring were ordered for all three oxygen rooms. These signs were placed on the door on 06/13/25. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur all staff will be in-serviced on the transferring and storage of oxygen procedure (Attachment J). To monitor the corrective actions and ensure the deficient practice will not recur, the DON /Designee	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 01 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfilling is occurring at all times and no way to indicate when transfilling is not occurring. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0000 Bldg. 02	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: 05/27/25 Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,	K 0000	On May 27, 2025, an annual life safety code survey was conducted. A plan of correction was formally implemented upon receipt of the CMS Form 2567. Attached is the plan of correction, all pertinent attachments, and the facility representative's signature on page one of the 2567. Please review the submitted plan of correction to the cited deficiencies and contact us should you have any questions following the review of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This facility consists of two buildings with different construction types. Building One, the existing health care and memory care three story building with a partial basement was determined to be of Type II (111) construction and fully sprinklered. Building Two, the new therapy addition one story building was determined to be of Type V (111) construction and fully sprinklered. The buildings were separated by a two-hour fire wall. Building Two has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 127 and had a census of 87 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/02/25			
K 0211 SS=F Bldg. 02	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to maintain the means of egress through 1 of 4 exits egresses in Building Two in accordance with LSC section 7.2.1.14 Horizontal-Sliding Door Assemblies which states, horizontal-sliding door assemblies shall be permitted in means of egress, provided that all of the following criteria are met: (1) The door leaf is readily operable from either side without special knowledge or effort. (2) The force that, when applied to the operating device in the direction of egress, is required to operate the door leaf is not more than 15 lbf (67	K 0211	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The doors were immediately worked on and the breakaway feature is operational for both sets of doors in this building are now working.	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	N). (3) The force required to operate the door leaf in the direction of travel is not more than 30 lbf (133 N) to set the leaf in motion and is not more than 15 lbf (67 N) to close the leaf or open it to the minimum required width. (4) The door leaf is operable using a force of not more than 50 lbf (222 N) when a force of 250 lbf (1100 N) is applied perpendicularly to the leaf adjacent to the operating device, unless the door opening is an existing horizontal-sliding exit access door assembly (5) The door assembly complies with the fire protection rating, if required, and, where rated, is self-closing or automatic closing by means of smoke detection in accordance with 7.2.1.8 and is installed in accordance with NFPA80. This deficient practice affects all residents in Building Two. Findings include: Based on observation with the Maintenance Director and the Administrator on 05/27/25 at 10:39 a.m., the front east exit had two sets of horizontal-sliding door assemblies, one set of interior doors and one set of exterior doors. Both sets of doors did open automatically but when the push breakaway feature was tested on the exterior doors, the doors did not open. Based on an interview at 10:39 a.m., the Maintenance Director agreed the exterior doors would not swing open when the breakaway feature was 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)		All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur the maintenance supervisor was in-serviced on NFPA chapter 7 specifically on the means of egress section (Attachment F) To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 3 (Attachment E). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0291 SS=C Bldg. 02	NFPA 101 Emergency Lighting Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 4 of 4 battery backup lights in Building Two. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice affects all residents in Building One. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/27/25 at 10:55 a.m., in the TELS system, the battery-operated lights in Building Two were tested monthly and annually but did not contain an itemized list to show that each emergency light in the facility was tested. Based on an interview at 10:55 a.m., the Maintenance Director stated the monthly and annual battery-operated lights testing was checked off in the TELS system but was unable to list each light in the TELS system. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)	K 0291	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. Maintenance supervisor itemized each of the battery-operated lights to help track testing. All residents have the potential to be affected by the same deficient practice. An audit was conducted to see if any lights were not itemized and no issues were noted. To ensure that the deficient practice does not recur The Maintenance supervisor was in-serviced on the requirements of NFPA 7.9.3.1.1 (Attachment F). To monitor the corrective actions and ensure the deficient practice will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 1 (Attachment C). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler system gauges in Building Two were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents in Building Two. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/27/25 at 11:48 a.m., the facility's sprinkler system in Building Two had two pressure gauges with a manufactures date of 2019, and no recalibration date information was affixed to the sprinkler system gauges. Based on interview at 11:48 p.m., the Maintenance Director agreed the two gauges were older than five years and have not been recalibrated. The findings were reviewed with the	K 0353	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The identified gauges were replaced by an outside vendor. All residents have the potential to be affected by the same deficient practice. Currently the facility has no other sprinkler system gauges that are needing recalibrated or replaced. To ensue the deficient practice will not recur the Maintenance supervisor was in-serviced on NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. To monitor the corrective actions, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 Tracker 3 (Attachment E). This tool will be completed daily (5 days/week) for 2 weeks, then weekly for 6 weeks, then monthly for 4 months, and quarterly thereafter and will be	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		reviewed in one year by the Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 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. Findings include: Based on records review with the Maintenance Director and the Administrator on 05/27/25 at 10:39 a.m., the following shifts did not have fire drills at unexpected times: a. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place around 2:00 p.m. b. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place around 5:00 a.m. Based on an interview at 10:39 a.m., the Maintenance Director and the Administrator agreed fire drills for two shifts were not held at unexpected times. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m.	K 0712	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. A fire drill was held at an unexpected time varying from previous drills. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur The Environmental Services Director was in-serviced on the requirement to hold fire drill at unexpected times under varying conditions (Attachment F.) To monitor the corrective actions and ensure the deficient practice	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b) 3.1-51(c)		will not recur, the ADM /Designee will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a 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 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 3 of 4 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 8 residents in the therapy gym. Findings include: Based on observations with the Maintenance Director and the Administrator on 05/27/25 at 11:57 a.m., three power strips were in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on an interview at 11:57 a.m., the Maintenance Director agreed three power strips were in use in a resident care area and did not meet 1363A or 60601-1.	K 0920	It is the policy of Miller's Merry Manor to operate in a fashion so the safety of the residents always comes first. The power strips were immediately taken away. All residents have the potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur all staff were in-serviced on the power strip	06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155235	A. BUILDING 02 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 3:10 p.m. 3.1-19(b)		policy (Attachment B). To monitor the corrective actions and ensure the deficient practice will not recur, the DON /Designee will complete the QA Tool titled Annual Survey 05/27/25 (Attachment D). This tool will be 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 Quality Assurance (QA) team to determine the frequency of the audit. Any concerns will be addressed immediately and have a Quality Assurance and Quality Improvement Action Plan completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate.	