STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155173	A. BUILDING -- B. WING	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

(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: 02/21/24 Facility Number: 000089 Provider Number: 155173 AIM Number: 100287760 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 176 and had a census of 66 at the time of this survey. Quality Review completed on 02/23/24	E 0000	March 8, 2024 Indiana State Department of Health Division of Long-Term Care, Section 4 B 2 North Meridian Street Indianapolis, Indiana 46204 To Whom it May Concern: A Life Safety Code Recertification and State Licensure with the Emergency Preparedness Survey was conducted at Miller's Merry Manor of Marion on February 21, 2024. Please find the enclosed Plan of Correction being submitted as remedies to the deficiencies that were found during our survey. All systemic changes and education will be completed by March 21, 2024. With regards to our Plan of Correction from the February 21, 2024 Annual Survey we hope that you will find our remedies both sufficient and thoroughly explained in providing a clear picture of how we corrected these concerns. We respectfully request *paper compliance* for this plan of correction for all four K Tags with a low level of scope and severity. All areas will have been corrected within 30 days of the survey, none of which were actual harm to any residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	03/13/2024

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

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			We will continue to abide by our plan of correction as indicated, and will continue to monitor, through audits and correct any future areas of concern per our plan of correction. If you have any questions or require additional information, please contact me at 765 662 3981 Thank you. Sincerely, Paula Juday, HFA, LMSW	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/21/24 Facility Number: 000089 Provider Number: 155173 AIM Number: 100287760 At this LSC 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, LSC, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully	K 0000	March 8, 2024 Indiana State Department of Health Division of Long-Term Care, Section 4 B 2 North Meridian Street Indianapolis, Indiana 46204 To Whom it May Concern: A Life Safety Code Recertification and State Licensure with the Emergency Preparedness Survey was conducted at Miller's Merry Manor of Marion on February 21, 2024. Please find the enclosed Plan of Correction being submitted as remedies to the deficiencies that were found during our survey. All systemic changes and education will be completed by March 21, 2024.	

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 176 and had a census of 66 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a garage used for the storage of lawn equipment and maintenance supplies. Quality Review completed on 02/23/24		With regards to our Plan of Correction from the February 21, 2024 Annual Survey we hope that you will find our remedies both sufficient and thoroughly explained in providing a clear picture of how we corrected these concerns. We respectfully request *paper compliance* for this plan of correction for all four K Tags with a low level of scope and severity. All areas will have been corrected within 30 days of the survey, none of which were actual harm to any residents. We will continue to abide by our plan of correction as indicated, and will continue to monitor, through audits and correct any future areas of concern per our plan of correction. If you have any questions or require additional information, please contact me at 765 662 3981 Thank you. Sincerely, Paula Juday, HFA, LMSW	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 26 of 26 resident's closet doors were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice affects 26 residents on hall South-2. Findings include: Based on observation with the Maintenance Director and the Administrator on 02/21/24 Between 11:00 a.m., and 12:00 p.m., all resident's closet doors on the South 2 hall were locked with a device from the outside and there was no release from the inside to open the door if locked. This condition could trap a person inside the closets if locked from the outside. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed the closet doors were locked form the outside and could not open from the inside when locked. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	**K 211 Means of Egress** **It is the policy of Miller's Merry Manor that the means of egress is continuously maintained free of all obstructions to full use in case of emergency.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** 26 resident's closet doors on S2 hall contained locks. All locks have been removed from those resident's closet doors. 3/7/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents had the potential to be affected by this deficient practice. A 100% audit of all closet doors in the facility was completed with no other resident's closet doors containing a lock. (Attachment A – Facility Layout). 3/7/2024 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Once the closet door locks on the South 2 hall are removed, the Maintenance Director and Administrator will inspect the 26 doors to ensure that all door locks have been removed. The	03/07/2024

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			Maintenance Director and all facility management was provided with education that no other locks would be placed on resident's closet doors. (Attachment B) 3/7/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)?** The facility Maintenance Director or designee will complete an audit (Attachment C-Quality Assessment / Improvement Program Life Safety Code) of the resident's closet doors to ensure compliance with having no lock. This will be completed 5X per week for 8 weeks, weekly X 10 weeks, and monthly X 2 months or until the facility reaches 100% compliance and the QAPI team determines that the issue is resolved.	
K 0361 SS=F Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 4 of 4 alcoves with a large quantity of combustible storage open to the corridor was not used as hazardous storage. LSC	K 0361	**K 361 Corridors – Area Open to Corridor** **It is the policy of Miller's Merry**	03/07/2024

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	19.3.6.1(7) states Spaces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice affects all residents. Findings include: Based on observation with the Maintenance Director and Administrator on 02/21/23 between 11:00a.m. and 12:30 p.m., alcoves on halls N-1, N-2, S-1, and S-2 were open to the corridor and were being used to store combustible material such as carts containing large amounts of linens. This condition created a hazardous area open to the corridor. Based on interview at the time of observation, Maintenance Director agreed the alcoves were open to the corridor, stating the alcoves were being to store carts of linen, and the items will be removed. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**Manor that all spaces open to the corridor are free from hazardous storage.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The carts containing linens and combustible items on all 4 halls (N1, N2, S1, and S2) were removed from the alcoves and placed in closed storage areas. 3/7/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. A 100 % audit was completed by the Administrator and Maintenance Director of all other areas in the facility to ensure that no other areas open to the corridor were being used as storage areas. (Attachment A – Facility Layout). 3/7/2024 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Once the combustible items were removed from the corridor, the Maintenance Director and Administrator inspected the areas to ensure that all combustible items were removed and placed in	

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			new areas designated as storage areas for each unit. All management staff were educated regarding the new storage areas. (Attachment B) 3/7/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)?** The facility Maintenance Director or designee will complete an audit (Attachment C-Quality Assessment / Improvement Program Life Safety Code) of the facility to ensure compliance with having no combustible items being stored in areas open to the corridor. This will be completed 5X per week for 8 weeks, weekly X 10 weeks, and monthly X 2 months or until the facility reaches 100% compliance and the QAPI team determines that the issue is resolved.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

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	Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 6 of 12 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 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 smoke. This deficient practice affects all residents. Findings include: Based on observations with the Maintenance Director on 02/21/24 between 12:45 p.m. and 1:15 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of the North-1 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall unsealed. b) Above the drop ceiling of the North-2 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall unsealed. c) Above the drop ceiling of the North-3 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall unsealed. d) Above the drop ceiling of the South-1 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall	K 0372	**K372** **It is the policy of Miller's Merry Manor that penetration of smoke barriers be protected to maintain the smoke resistance of each smoke barrier.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The metal beams above the ceiling of 6 halls (N1, N2, N3, S1, S2, S3) were believed to have penetrated the wall. All 6 beams were inspected and none of the 6 beams did penetrate the wall. All 6 beams have caulk around the beam that fell out. The facility Maintenance Director ordered spray foam to caulk around all 6 beams. Upon receiving the spray foam (scheduled to arrive 3/12/2024), the facility Maintenance Director and Corporate Services staff will spray the area around all 6 beams, where it appears to penetrate the wall. The Spray Foam ordered is BOSS 813, which meets ASTM E-814 (UL1479) standards (Attachment F). Completion date will by 3/21/2024. **How other residents having the potential to be affected by the same deficient practice will be**	03/21/2024

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	unsealed. e) Above the drop ceiling of the South-2 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall unsealed. f) Above the drop ceiling of the South-3 smoke wall had a metal beam through the wall and the caulk around the beam fell out leaving the wall unsealed. Based on an interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. A 100% audit of smoke barriers in the facility was completed with no other smoke barrier having old caulk, needing caulk replaced. (Attachment A – Facility Layout). 3/7/2024 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The SEMI-ANNUAL PREVENTIVIE MAINTENANCE REPORT was updated to include a semi annual check of all caulking around the smoke barrier walls / beams. This will include the months of February and August of each year going forward (Attachment D). 3/7/2024 **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)?** The facility Maintenance Director or designee will complete an audit (Attachment C-Quality Assessment / Improvement Program Life Safety Code) of the facility to ensure compliance with smoke barriers having caulking added. This will be completed 5X per week for 8 weeks, weekly X 10 weeks, and monthly X 2 months or	

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			until the facility reaches 100% compliance and the QAPI team determines that the issue is resolved.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 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.	K 0920	**K 920 Electrical Equipment – Power cords and Extension Cords** **It is the policy of Miller's Merry Manor to use electrical power strips in accordance to NFPA 70, National Electrical Code,**	03/07/2024

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	This deficient practice could affect two residents in room 150. Findings include: Based on observations with the Maintenance Director and Administrator on 02/21/24 at 12:45 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power-strip in room 150. Based on interview at the time of observation, the Maintenance Director acknowledged a power-strip was supplying power to high power draw equipment. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**which prohibits the use of power strips for refrigerators.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** One resident's personal refrigerator in room 150 was plugged into a power strip. That resident's refrigerator was immediately unplugged and plugged directly into the wall plug. 2/21/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. A complete 100 % audit of the facility was completed to ensure that no other rooms had high power draw equipment plugged into a power strip. All other high powered equipment was in compliance. (Attachment A – Facility Layout). 2/21/2024 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The facility Maintenance Director educated all managers of the Electrical Power Strip Policy. (Attachment B) (Attachment E) 3/7/2024	

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			How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)? The facility Maintenance Director or designee will complete an audit (Attachment C-Quality Assessment / Improvement Program Life Safety Code) of the facility to ensure compliance with having no high power draw equipment plugged into a power strip. This will be completed 5X per week for 8 weeks, weekly X 10 weeks, and monthly X 2 months or until the facility reaches 100% compliance and the QAPI team determines that the issue is resolved.	