PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

VIDER OR SUPPLIER SUMMARY S (EACH DEFICIENCY REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	259 W	ADDRESS, CITY, STATE, ZIP COD HARRISON ST ESVILLE, IN 46158  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETED 01/07/2025  (X5) COMPLETION DATE
VIDER OR SUPPLIER  SUMMARY S  (EACH DEFICIENCY  REGULATORY OR  In Emergency Preponducted by the Inc	155564  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	B. WING  STREET 259 W  MOOR  ID  PREFIX	HARRISON ST ESVILLE, IN 46158  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	01/07/2025  (X5)  COMPLETION
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An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 01/07/25  Facility Number: 000398 Provider Number: 155564 AIM Number: 100291110  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 98 certified beds. At the time of the survey, the census was 58.  Quality Review completed on 01/09/25		E 0000	Please accept this Plan of Correction for the Life Safety Co Survey ending January 7, 2025 the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correctio with a completion date of 1/28/2025.	as e
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: 01/07/25  Facility Number: 000398 Provider Number: 155564 AIM Number: 100291110  At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with		K 0000	Survey ending January 7, 2025 the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit	as :
ttttlerend LL	ility Number: 0 vider Number: 1002 his Emergency I ry Manor was for ergency Preparedicare and Medicare survey, the censulity Review condition of the ensure Survey was artment of Heal 190(a).  Wey Date: 01/07 vider Number: 0 vider Number: 1002	ility Number: 000398 vider Number: 155564  M Number: 100291110  his Emergency Preparedness survey, Miller's rry Manor was found in compliance with ergency Preparedness Requirements for dicare and Medicaid Participating Providers Suppliers, 42 CFR 483.73  facility has 98 certified beds. At the time of survey, the census was 58.  dity Review completed on 01/09/25  iffe Safety Code Recertification and State ensure Survey was conducted by the Indiana partment of Health in accordance with 42 CFR .90(a).  vey Date: 01/07/25  ility Number: 000398 vider Number: 155564  M Number: 100291110	ility Number: 000398 vider Number: 155564 M Number: 100291110 his Emergency Preparedness survey, Miller's rry Manor was found in compliance with ergency Preparedness Requirements for dicare and Medicaid Participating Providers Suppliers, 42 CFR 483.73 facility has 98 certified beds. At the time of survey, the census was 58. dity Review completed on 01/09/25  iffe Safety Code Recertification and State ensure Survey was conducted by the Indiana partment of Health in accordance with 42 CFR 190(a).  vey Date: 01/07/25 ility Number: 000398 vider Number: 155564 M Number: 100291110	ility Number: 000398 vider Number: 155564 4 Number: 100291110 with a completion date of 1/28/2025.  Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correctio with a completion date of 1/28/2025.  Respectively Reparedness survey, Miller's rry Manor was found in compliance with ergency Preparedness Requirements for dicare and Medicaid Participating Providers Suppliers, 42 CFR 483.73  facility has 98 certified beds. At the time of survey, the census was 58.  Ality Review completed on 01/09/25  If Safety Code Recertification and State ensure Survey was conducted by the Indiana partment of Health in accordance with 42 CFR and the provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction for the Life Safety Code Survey ending January 7, 2025 the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction for the Life Safety Code Survey ending January 7, 2025 the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction for the Life Safety Code Survey ending January 7, 2025 the Provider's Letter of Credible Allegation of Compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey for this Plan of Correction for paper compliance in lieu of a revisit survey fo

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

TITLE (X6) DATE

Natalie Peterson Executive Director 01/22/2025

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JQRR21 Facility ID: 000398 If continuation sheet Page 1 of 4

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155564  NAME OF PROVIDER OR SLIPPLIER  NAME OF PROVIDER OR SLIPPLIER  IN COMPLETED  STREET ADDRESS, CITY, STATE, ZIP COD  259 W HARRISON ST  MOORESVILLE, IN 46158  SIRVERY MANOR  (X4) ID  SIMMARY STATEMENT OF DEFICIENCIE:  (EACH DEPTICENCY MOST BE PRECEDED BY FULL  REQUIREMENTS for Participation in  Medicace/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 for Color, Chapter 19, Existing  Health Care Occupancies and 410 LAC 16.2.  This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces upen to the corridors, plus hattery operated smoke alarms in all residents leceping rooms. The facility has a capacity of 98 and had a census of 58 at the time of this survey.  All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.  Quality Review completed on 01/09/25  K 0921  NFPA 101  Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interieve, the facility failed to conduct the required maintenance and maintain complete documentation of imspections for Patient Care Related Flectrical Equipment (PCRET). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical systems analyzer was ordered to complete testing on all PCREE.  A 100% south will be completed on all PCREE to ensure	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
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Any system consisting of several electrical on all PCREE to ensure						_		
						-		
appliances demonstrates compliance with NFPA appropriate testing was completed			_			appropriate testing was compl	leted	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JQRR21 Facility ID: 000398

If continuation sheet Page 2 of 4

PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		01	COMPLETED		
155564		B. WING			01/07/2025		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					HARRISON ST		
MILLER'S MERRY MANOR			MOORESVILLE, IN 46158				
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	99 as a complete sy	stem. Service manuals,			and documented, and no furth	er	
	instructions, and pro	ocedures provided by the			concerns were identified		
	manufacturer includ	le information as required by			(Attachment A) To prevent		
	10.5.3.1.1 and are c	onsidered in the development			recurrence, a new policy and		
	of a program for ele	ectrical equipment maintenance.			procedure was initiated titled		
	Electrical equipmen	nt instructions and maintenance			"PCREE Policy & Procedure"		
	manuals are readily	available, and safety labels			(Attachment B) to ensure testi	ng	
		rating instructions on the			is completed and documented	_	
	-	e. A record of electrical			All residents utilizing PCREE I		
		pairs, and modifications is			the potential to be affected by		
	maintained for a per	riod of time to demonstrate			deficient practice. A 100% aud		
	compliance in accordance with the facility's				will be completed on all PCRE		
	policy. Personnel responsible for the testing,				ensure appropriate testing wa		
		e of electrical appliances			completed and documented, a		
	receive continuous training. This deficient				no further concerns were iden		
	practice affects all residents.				by 1/28/2025. Any PCREE		
	*				identified as faulty will be		
The findings include:				immediately removed from use	е		
	The monge metado.				upon discovery, and assessed		
	Based on records re	view, interview and facility			modifications or repairs.		
	tour with the Execu	_			To prevent recurrence, a new		
	Maintenance Director (MD) and Senior				policy and procedure was initia		
	Maintenance Director (SMD) on 01/07/25				titled "PCREE Policy & Proced		
		and 2:45 p.m., no documentation			(Attachment B) to ensure testi		
		view for the testing of the			is completed in accordance wi	•	
	PCREE in use throughout the facility, as required				regulation, and documented		
	by section 10.5.6.2 of NFPA 99, Health Care				appropriately. This includes		
	Facilities Code. Observation during the building				completing annual retesting of	f	
	tour revealed that the facility provided electric				equipment and noting any rep		
	beds for all residents. The ED stated that PCREE				or modifications.		
	such as nebulizers, oxygen concentrators, vital				All Maintenance staff were		
	signs monitors, and other electrical medical				inserviced on 1/8/25 regarding	y	
	equipment was present and in use at the facility.				PCREE Policy & Procedure a		
	Both the ED and SMD stated that the facility was				Audit Too (Attachment C).		
	not aware that the PCREE was required to be				Maintenance Director/Designe	ee	
	tested.				will monitor PCREE testing		
	This finding was acknowledged by the ED. MD				through the use of the		
	and SMD at the time of discovery and again at the				Maintenance Services QA Too	o/	
	exit conference with each present.				(Attachment D).		
					Attachment D will be utilized		
			1				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155564	B. WING			01/07/2025	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 259 W HARRISON ST MOORESVILLE, IN 46158				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	3.1-19(b)				weekly x4 weeks, monthly x3 months, and quarterly thereafte ensure responsible staff are completing PCREE testing.	er to	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JQRR21 Facility ID: 000398 If continuation sheet Page 4 of 4