CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESIGNACIES (V1) PROVIDED (SURPLIED (CLIA					ONIB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155573	B. WING		08/16/2022
	PROVIDER OR SUPPLIER		981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356	•
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
E 0000	REGGENTORT OF	CESC ISENTI TING IN ORDINION	1710		Ditte
Bldg	conducted by the In accordance with 42 Survey Date: 08/16 Facility Number: 0 Provider Number: 100 At this Emergency Merry Manor was f Emergency Prepare Medicare and Mediand Suppliers, 42 C	5/22 500342 155573 289140 Preparedness survey, Miller's found in compliance with edness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of	E 0000		
	Quality Review con	mpleted on 08/17/22			
K 0000					
Bldg. 01	A Life Sefety Co.1-	Recertification and State	W 0000		
	Licensure Survey w	vas conducted by the Indiana Ith in accordance with 42 CFR	K 0000		
	Survey Date: 08/16	5/22			
	Facility Number: 0 Provider Number: AIM Number: 100	155573			
	-	Code survey, Miller's Merry ot in compliance with			

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

TITLE (X6) DATE

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: OE2X21 Facility ID: 000342 If continuation sheet Page 1 of 15

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/16/2022	
	ROVIDER OR SUPPLIER		981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR Requirements for Pa	LSC IDENTIFYING INFORMATION articipation in	TAG	DEFICIENCY)	DATE
	Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (L	, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, .SC), Chapter 19, Existing ancies and 410 IAC 16.2.			
	Type V (000) construction The facility has a find etection in the corrections, and batter all resident sleeping	ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the ry operated smoke detectors in grooms. The facility has a nad a census of 19 at the time			
	were sprinkled and services were sprink	dents have customary access all areas providing facility kled. The facility had a orage building which was not			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record rev	n - Testing and n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 riew and interview, the facility	K 0345	To immediately correct the	09/16/2022
	failed to ensure 1 of	1 fire alarm systems was dance with LSC 9.6.1.3. LSC		problem, the previously identifailed smoke detectors (via	

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 2 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155573	B. W	ING		08/16/2	2022
		<u></u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	K			ECHWOOD AVE		
MILLER'	S MERRY MANOR			MIDDLETOWN, IN 47356			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	_	re alarm system to be installed,			sensitivity testing) were replace		
	· ·	ned in accordance with NFPA			All residents had the potential	to	
		cal Code and NFPA 72,			be affected by the deficient	_	
		n Code. NFPA 72, Section otherwise permitted by other			practices. Replacement of the	e	
		le, testing shall be performed			failed smoke detectors as		
		the schedules in Table 14.4.5,			described above protected all residents.		
		uired by the authority having			To ensure the deficient practic		
	_	. 72, Section 14.4.5.3.1 states			does not recur, the administra		
	· ·	sitivity shall be checked within			and the Maintenance Director		
		tion. NFPA 72, 14.4.5.3.2 states			were educated on LSC 9.6.1.3		
	smoke detector sensitivity shall be checked every				(NFPA 70 & 72). Additionally		
		after unless otherwise			system was initiated where we		
	permitted by compliance with Section 14.4.5.3.3.				orders for external vendors wi		
	This deficient practice could affect all occupants.				now be part of the existing into		
	This deficient practice could affect all occupants.				work order system. In doing s		
	Findings include:				log will be kept, and items will		
					be removed until work is	1101	
	Based on record rev	view and interview with the			completed by external vendor	s.	
		Director of Maintenance on			To monitor and ensure the		
		0:15 a.m. and 12:30 p.m., the fire			deficient practice does not red	cur. a	
		10/11/21 stated that 4 smoke			Quality Assurance tool titled:	,	
	-	sensitivity test and needed to			"LSC Survey POC 2022"		
		cumentation was available for			(Attachment A) was		
	review indicating re	eplacement of the failed			implemented. This tool will be	•	
	_	rector of Maintenance sought			completed 5x per week for fou		
	additional paperwor	rk from the facilities contractor			weeks, weekly for four weeks	, and	
	during the survey, b	out by the end of the survey,			monthly thereafter until it is		
	not other document	ation was provided.			reviewed by the QAPI team a	nd a	
					determination made for appro	priate	
	The finding was rev	viewed with the Director of			ongoing use.		
		time of discovery and again			All systemic changes will be		
	-	Ference with the Administrator			made by 9/16/22.		
	at 2:15 p.m.						
	3.1-19(b)						
K 0346	NFPA 101						
SS=C	Fire Alarm Systen	n - Out of Service					
Bldg. 01	Fire Alarm - Out o						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155573	B. W	NG		08/16	/2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ECHWOOD AVE		
MILLER'	S MERRY MANOR				ETOWN, IN 47356		
IVIILLLIX	- WEIGHT WANDIN			MIDDE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Where required fi	re alarm system is out of					
		than 4 hours in a 24-hour					
	period, the authority having jurisdiction shall be notified, and the building shall be						
		approved fire watch shall be					
		arties left unprotected by the					
		e fire alarm system has					
	been returned to service. 9.6.1.6 Based on record review and interview, the facility						
			K 0	346	*An Informal Dispute Resolution		09/16/2022
	•	complete 1 of 1 written policy			(IDR) request has been made		
	for the protection of residents indicating				the facility does not agree with		
	procedures to be followed in the event the fire				alleged citation received durin	•	
	alarm system has to be placed out of service for four hours or more in a twenty four hour period in				survey. However, as required	by	
		-			ISDH, even when the facility	.	
		SC, Section 9.6.1.6. This			disagrees with a finding, a Pla		
	deficient practice a	ffects all occupants.			Correction must be made and		
	Findings include:				submitted. Please see the		
	rindings include.				required POC below:		
	Bosed on record re	view and interview with the			To immediately correct the problem, the Fire Watch Polic	.,	
		Director of Maintenance on			(Attachment B) was modified	-	
		10:15 a.m. and 12:30 p.m., the fire			include contacting the Indiana		
		o include contacting the			State Department of Health Vi		
	_	rtment of Health via the ISDH			the ISDH Gateway Link at	u	
	_	ps://gateway.isdh.in.gov as the			https://gateway.isdh.in.gov as	the	
		by the secondary method when			primary method or by the	410	
		is nonoperational by			secondary method when ISDI	4	
	-	ident Reporting form and			Gateway is non-operational by		
		dents@isdh.in.gov. Based on			completing the Incident Repor	-	
	_	e record review, the			form and emailing it to inciden	-	
		lowledged the fire watch			@ ISDH.in.gov		
		vided stated to contact the			All residents had the potential	to	
	Indiana State Depar	rtment of Health via the ISDH			be affected by the deficient		
	Gateway link but n	ot at the e-mail address listed			practices. Changes to the Fire	е	
	above.				Watch Policy (Attachment B),		
					outlined above, protect all		1
	The finding was re-	viewed with the Administrator			residents from the alleged		
	at the time of disco	very and again during the exit			deficient practice.		
	conference with the	e Administrator at 2:15 p.m.			To ensure the alleged deficier	nt	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155573	B. WI	NG		08/16/	2022
	ROVIDER OR SUPPLIER		•	981 BEI	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any rautomatic sprinkler	supply source RKS information on non-required or partial er system.			practice does not recur, the administrator and the Maintena Director were educated on LSG 9.6.1.6. To monitor and ensure the deficient practice does not reconstructed to titled: "LSC Survey POC 2022" (Attachment A) was implemented. This tool will be completed 5x per week for four weeks, weekly for four weeks, monthly thereafter until it is reviewed by the QAPI team and determination made for appropongoing use. All systemic changes will be made by 9/16/22.	C ur, a r and ad a	
	9.7.5, 9.7.7, 9.7.8,	and NFPA 25	1				

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 5 of 15

10/04/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/16/2022 155573 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 981 BEECHWOOD AVE MIDDLETOWN, IN 47356 MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0353 To immediately correct the 09/16/2022 failed to ensure 1 of 1 sprinkler systems were problem, a new cabinet was provided with spare sprinklers, a spare sprinkler ordered to store the sprinkler cabinet and a sprinkler wrench on the premises. heads. The sprinkler heads are NFPA 25, Standard for the Inspection, Testing, hanging and secured in the and Maintenance of Water-Based Fire Protection cabinet and not loose within the Systems, 2011 Edition, Section 5.4.1.4 states a cabinet, but each is placed in their supply of spare sprinklers (never fewer than six) "Own Holders" within the cabinet. shall be maintained on the premises so that any Additionally, 2 new (not previously sprinklers that have been operated or damaged in used) sprinkler heads for each any way can be promptly replaced. The sprinklers sprinkler type in the facility were shall correspond to the types and temperature ordered and are in place as ratings of the sprinklers on the property. The described above in the sprinkler sprinklers shall be kept in a cabinet located where cabinet. The previously used the temperature in which they are subjected will at sprinkler heads were removed. no time exceed 100 degrees Fahrenheit. A special All residents had the potential to sprinkler wrench shall be provided and kept in the be affected by the deficient cabinet to be used in the removal and installation practices. The new cabinet and of sprinklers. This deficient practice could affect sprinkler heads placed, as all residents and staff in the facility. described above, will prevent the alleged deficient practice from Findings include: affecting other residents. To ensure the alleged deficient Based on observation during a tour of the facility practice does not recur, the and interview with the Director of Maintenance on administrator and the Maintenance 08/16/22 between 12:30 p.m. and 2:15 p.m., there Director were educated on NFPA was one spare sprinkler cabinet in the riser room 25 Section 5.4.1.4. that included 12 spare sprinklers; 6 of which were To monitor and ensure the not in their own protected slot. They were stored deficient practice does not recur, a loose in the cabinet and not secured in holders. Quality Assurance tool titled: Additionally, 3 of the 12 spare sprinklers were "LSC Survey POC 2022" used, showing obvious signs of previous (Attachment A) was installation. Based on interview at the time of the implemented. This tool will be observation, the Director of Maintenance agreed completed 5x per week for four the spare sprinkler cabinet had spare sprinklers weeks, weekly for four weeks, and not in protected slots and some of the spares monthly thereafter until it is

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

appeared to be previously used.

The finding was reviewed with the Director of

Maintenance at the time of discovery and again

Event ID:

OE2X21

Facility ID: 000342

ongoing use.

If continuation sheet

reviewed by the QAPI team and a determination made for appropriate

All systemic changes will be

Page 6 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION C	X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155573	B. WING 08/16/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE MIDDLETOWN, IN 47356				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ference with the Administrator	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) made by 9/16/22.	(X5) COMPLETION DATE		
K 0354 SS=C Bldg. 01	extent and duratic been determined, are inspected and recommendations management or d and the fire depar having jurisdiction the sprinkler systethan 10 hours in a building or portion evacuated or an a provided until the returned to servic 18.3.5.1, 19.3.5.1 Based on record revalled to provide 1 event the automatic placed out-of-servic 24-hour period in a 9.7.5. LSC 9.7.6 reprocedures comply the Standard for the Maintenance of Wasystems. NFPA 25 procedures that the follow. A.15.5.2 (4 consist of trained patrol the affected a extinguishers and the	- Out of Service er system is impaired, the on of the impairment has areas or buildings involved I risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where em is out of service for more a 24-hour period, the of the building affected are approved fire watch is sprinkler system has been	K 0354	*An Informal Dispute Resolution (IDR) request has been made a the facility does not agree with talleged citation received during survey. However, as required by ISDH, even when the facility disagrees with a finding, a Plan Correction must be made and submitted. Please see the required POC below: To immediately correct the problem, the Fire Watch Policy (Attachment B) was modified to include contacting the Indiana State Department of Health Via the ISDH Gateway Link at	s the the py of		

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

consider. During the patrol of the area, the person

Event ID:

OE2X21

Facility ID: 000342

If continuation sheet

https://gateway.isdh.in.gov as the

Page 7 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155573		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/16/2022	
	PROVIDER OR SUPPLIER		981 BI	CADDRESS, CITY, STATE, ZIP COD EECHWOOD AVE LETOWN, IN 47356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION OPRIATE DATE
	should not only be I sure that the other f building such as ega are available and fu deficient practice of facility. Findings include: Based on record reve Administrator and I 08/16/22 between I watch plan failed to Indiana State Depar Gateway link at http://primary method or the ISDH Gateway completing the Incider-mailing it to incide interview during the Administrator acknown documentation proving Indiana State Depar Gateway link but no above. The finding was reveat the time of discoverence with the 3.1-19(b)	ooking for fire, but making ire protection features of the ress routes and alarm systems nctioning properly. This buld affect all occupants in the priew and interview with the Director of Maintenance on 0:15 a.m. and 12:30 p.m., the fire include contacting the tement of Health via the ISDH os://gateway.isdh.in.gov as the by the secondary method when is nonoperational by dent Reporting form and ents@isdh.in.gov. Based on		primary method or by the secondary method when Gateway is non-operation completing the Incident R form and emailing it to inc@ ISDH.in.gov All residents had the pote be affected by the deficien practices. Changes to the Watch Policy (Attachmentoutlined above, protect all residents from the alleged deficient practice. To ensure the alleged deficient practice does not recur, the administrator and the Mai Director were educated on 9.6.1.6. To monitor and ensure the deficient practice does not Quality Assurance tool title "LSC Survey POC 2022" (Attachment A) was implemented. This tool was completed 5x per week for weeks, weekly for four	ISDH ial by eporting cidents Intial to int e Fire it B), as if icient ine intenance in LSC e it recur, a ed: ill be or four eeks, and is is im and a opropriate
K 0363 SS=E Bldg. 01	than required encl exits, or hazardou	corridor openings in other osures of vertical openings, s areas resist the passage made of 1 3/4 inch			

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 8 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573			UILDING	01	COMPLI 08/16/	ETED	
	PROVIDER OR SUPPLIER			981 BE	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller later CMS regulation. The apply to auxiliary such flammable or complying with the correct covering is not extend to covering is not extend to cover complying with the door closed with a cover complying of the door closed with a political covers. The cover complying of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be later to the cover	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are in sprinklered compartments ctions in area or fire as or frames in window Parts 403, 418, 460, 482, as details of doors such as angs, automatics closing on and interview, the facility	K 0.	363	To immediately correct the		09/16/2022
	failed to ensure all of impediment to closi	corridor doors had no ing and latching into the door sist the passage of smoke.	K 0.	303	problem, the Resident Room # HK Supply Closet near employ entrance, Dietary Supply Roon	/ee	09/16/2022

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 9 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155573	B. W	NG		08/16/	2022
				CTD FET	ADDRESS STEW STATE ZID SOD		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MULTER!	O MEDDY MANIOD				ECHWOOD AVE		
MILLERS	S MERRY MANOR			MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	This deficient pract	ice could affect 6 staff and 15			Mops Supply Closet,		
	residents.				Kitchen/Dining room door, doo	r all	
	Findings include:				had adjustments made to the		
					door, and the closures to ensu	re	
					the doors close in accordance		
	Based on observation	on during a tour of the facility			with NFPA 19.3.6.3. Additiona	ally	
		the Director of Maintenance on			an air analysis was performed	•	
	08/16/22 between 12:30 p.m. and 2:15 p.m., the				a heating and air vendor to as		
		loors failed to latch positively			with adjusting negative pressu		
	_				that could contribute to the pro		
	into their respective door frames: a) Resident Room #26				closure of the doors. The	PO.	
	b) Housekeeping Supply Closet near the				Kitchen/supply room door is be	eina	
	employee entrance, equipped with a self-closing				special built and will be replace	-	
	device.				on 9/16/22 to ensure the door	Ju	
	c) Dietary Supply Room near the employee				closes in accordance with NFF	οΔ	
	entrance, equipped with a self-closing device.				19.3.6.3.	, ,	
		Ploset in the Kitchen, equipped			All residents had the potential	to	
	with a self-closing of				be affected by the deficient	lo	
	_	nto the dining room. equipped			practices. Adjustment and		
	with a self-closing of						
	_	nto the Dietary Supply room,			replacement of the doors as outlined above, protect all		
	equipped with a sel		residents from the alleged				
	equipped with a ser	r-closing device.			deficient practice.		
	The finding was rev	viewed with the Director of			To ensure the alleged deficien	+	
	_	time of discovery and again			practice does not recur, the	ι	
		Erence with the Administrator			Maintenance Director was		
	at 2:15 p.m.	crence with the Administrator			educated on NFPA 19.3.6.3.		
	u. 2.15 p.m.				To monitor and ensure the		
	3.1-19(b)				deficient practice does not rec	ur o	
	3.1-17(0)				Quality Assurance tool titled:	ui, a	
					The state of the s		
					"LSC Survey POC 2022" (Attachment A) was		
					implemented. This tool will be		
					completed 5x per week for fou		
					weeks, weekly for four weeks,	ano	
					monthly thereafter until it is		
					reviewed by the QAPI team ar		
					determination made for approp	riate	
					ongoing use.		
			1		All systemic changes will be		

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X4) ID SUMMARY STATEMENT OF DEPICIENCIE PREFIX TAG ID PROVIDER OR SUPPLIER MILLER'S MERRY MANOR (X5) STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE MIDDLETOWN, IN 47356 (X5) COMPLETION DEPLIES ON THE PREPOPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG NFPA 101 SS=E Utilities - Gas and Electric Utilities - Gas and Electric Code, electrical wiring and equipment complies with NFPA 54, National Electric Code, electrical wiring and equipment or provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. 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(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B(II)) To minute and provided with grade and provided in 210.8(B(II)) To ensure the alleged deficient practice. To ensure the alleged deficient practice does not recur, the Maintenance Director was educated on LSC 19.1.2 and NFPA 70 NEC 2010.8. To monitor and ensure the	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
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Maintenance						(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
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(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles educated on LSC 19.1.2 and NFPA 70 NEC 210.8.		circuit-interrupter sl	hall be installed in a readily			_		
single-phase, 15- and 20-ampere receptacles NFPA 70 NEC 210.8.		accessible location.				Maintenance Director was		
		(B) Other Than Dw	elling Units. All 125-volt,			educated on LSC 19.1.2 and		
installed in the locations specified in 210.8(B)(1) To monitor and ensure the						NFPA 70 NEC 210.8.		
						To monitor and ensure the		
through (8) shall have ground-fault deficient practice does not recur, a			_			I	ur, a	
circuit-interrupter protection for personnel. Quality Assurance tool titled:			rotection for personnel.			1		
(1) Bathrooms "LSC Survey POC 2022"		* *				1		
(2) Kitchens (Attachment A) was		` '				1 '		
(3) Rooftops implemented. This tool will be						1		
(4) Outdoors completed 5x per week for four		` /	(2) and (4). December -1 41-4-					
Exception No. 1 to (3) and (4): Receptacles that are weeks, weekly for four weeks, and		•	•				and	
not readily accessible and are supplied by a monthly thereafter until it is branch circuit dedicated to electric snow-melting, reviewed by the QAPI team and a		•				_	ad a	
			<u>e</u> .			l -		
deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance determination made for appropriate ongoing use.							priat e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 08/16/2022		
	PROVIDER OR SUPPLIER		981 B	STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE MIDDLETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ILD BE ROPRIATE COMPLETION DATE	
	with 426.28 or 427. Exception No. 2 to only, where the consupervision ensure are involved, an asseconductor program shall be permitted foutlets used to support of the supervision and support of the sup	22, as applicable. (4): In industrial establishments ditions of maintenance and that only qualified personnel tured equipment grounding as specified in 590.6(B)(2) for only those receptacle only equipment that would are if power is interrupted or it is not compatible with GFCI exceptacles are installed within poutside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without (5): For receptacles located in sof general care or critical care facilities other than those exprotection shall not be required. It is one in the sociated showering the bays, and similar areas where the equipment, electrical hand Wet Locations, requires all the equipment within the area of the equipment within the area of the equipment within the area of the equipment of the body, and the is more subject to failure. The indicates the could affect staff and up to		All systemic changes will made by 9/16/22.	Bille	

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 12 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>				COMPLETED	
		155573	B. WI	NG		08/16/	2022	
	PROVIDER OR SUPPLIER			981 BEI	ADDRESS, CITY, STATE, ZIP COD ECHWOOD AVE ETOWN, IN 47356			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0761	and interview with the 08/16/22 between 1 machine near the enconnected to an electron being used to power with it's own water located within 3 fees not provided with g (GFCI). The Admin observation stated so receptacle was on a the finding was reveat the time of discovers.	on during a tour of the facility the Director of Maintenance on 2:30 p.m. and 2:15 p.m., the ice inployee entrance was etric receptacle which was in the freestanding ice machine, supply. The ice machine was it of the electric receptacle, and round fault circuit interruption inistrator at the time of the did not believe the GFCI circuit. Triewed with the Administrator very and again during the exit Administrator at 2:15 p.m.						
SS=E Bldg. 01	interview, the facilitinspection and testinassembly was comp 19.1.1.4.1.1 communities barriers required permitted only in compartments of the permitted only including all frames and sills in accordant NFPA 80, Standard Opening Protectives	on, records review, and ty failed to ensure annual ng of at least 1 fire door eleted in accordance of LSC unicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table ected by approved, listed, semblies and fire window r accompanying hardware, s, closing devices, anchorage, nee with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire	K 0'	761	To immediately correct the problem, the an inspection wa completed of the Oxygen Transfilling room door. All residents had the potential be affected by the deficient practices. Inspection of the Oxygen Transfer room door protects all residents from the deficiency. To ensure the alleged deficient practice does not recur, the Maintenance Director was educated on NFPA 80, 5.2.1. Additionally, a complete facility review was conducted with the assigned inspector and the Maintenance Director to ensur	to at	09/16/2022	

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

Event ID:

OE2X21 Facility ID: 000342

If continuation sheet Page 13 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155573		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/16/2022					
	PROVIDER OR SUPPLIER		981 BE	STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE MIDDLETOWN, IN 47356					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION door assemblies shall be inspected and tested not less than annually, and a written record of the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY) doors that required inspectic were maintained on the list of	COMPLETION DATE				
	inspection shall be sides to assembly. NFPA 80	signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both everall condition of door 0, 5.2.4.2 states as a minimum,		doors requiring inspection. To monitor and ensure the deficient practice does not re Quality Assurance tool titled "LSC Survey POC 2022"	ecur, a				
	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.			(Attachment A) was implemented. This tool will lead to completed 5x per week for for weeks, weekly for four week monthly thereafter until it is reviewed by the QAPI team	our s, and				
	(3) The door, frame noncombustible thr	, hinges, hardware, and eshold are secured, aligned, er with no visible signs of ssing or broken.		determination made for applied ongoing use. All systemic changes will be made by 9/16/22.	ropriate				
	listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open p	device is operational; that is, pletely closes when operated position.							
	closes before the ac (8) Latching hardwadoor when it is in th (9) Auxiliary hardwadoor	are operates and secures the ne closed position. For are items that interfere or							
	frame. (10) No field modif have been performe (11) Gasketing and	re not installed on the door or ications to the door assembly d that void the label. edge seals, where required, are							
	This deficient pract Findings include:	their presence and integrity. ice could affect 6 residents.							
	Based on record review and interview with the Administrator and Director of Maintenance on								

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155573	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/16/2022				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 981 BEECHWOOD AVE MIDDLETOWN, IN 17756						
MILLER'S MERRY MANOR			MIDDLETOWN, IN 47356						
(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		
140	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			140			DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OE2X21 Facility ID: 000342 If continuation sheet Page 15 of 15