		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/24/2024	
	ROVIDER OR SUPPLIER			7440 N	ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 825 E IN 47246	OUNTY ROAD 825 E	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		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: 07/24/24  Facility Number: 000286 Provider Number: 155579 AIM Number: 100291000  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 75 certified beds. At the time of the survey, the census was 36.		E 0000				
	Quality Review con	npleted on 07/26/24					
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0	000			
	Survey Date: 07/24	/24					
	Facility Number: 00 Provider Number: 1002	155579					
	-	Code survey, Miller's Merry ot in compliance with					

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

TITLE (X6) DATE

Alexa Robbins Administrator 08/08/2024

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QWNX21 Facility ID: 000286 If continuation sheet Page 1 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155579	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	CON	TE SURVEY MPLETED 24/2024
	ROVIDER OR SUPPLIER		7440 N	ADDRESS, CITY, STATE, ZIP I COUNTY ROAD 825 E IN 47246		
(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 CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	CFR Subpart 483.96 the 2012 edition of	articipation in Medicare, 42 O(a), Life Safety from Fire and the National Fire Protection ) 101, Life Safety Code (LSC)				
	Building 01, the ori determined to be of was fully sprinklere addition added to th building in 2003 is and was fully sprinklere	ity consists of three buildings. ginal building built in 1973 was Type V (111) construction and d. Building 02, the 300 Hall enorth part of the original of Type V (111) construction clered. Building 01 and eviewed with Chapter 19, the Occupancies.				
	main dining room a Building 03 was det and was fully sprink	Therapy, Community Room and ddition constructed in 2019. termined to be of Type V(111) tered. Building 03 was oter 18, New Health Care				
	detection in the corr smoke detectors in	re alarm system with smoke ridor and has battery operated all resident sleeping rooms. spacity of 75 and had a census this survey.				
	were sprinklered. T building providing	dents have customary access The facility has two detached facility maintenance and ich were not sprinklered.				
	Quality Review con	npleted on 07/26/24				
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING					

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

Event ID:

 $QWNX21 \quad \text{Facility ID:} \quad 000286$ 

If continuation sheet

Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155579 B. WING 07/24/2		2024			
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			•	7440 N	ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 825 E IN 47246	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	nd hospitals where required					
	by construction type	•					
	-	approved automatic					
		n accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.						
	• •	nstruction, alternative					
		es are permitted to be					
	•	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.						
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	1	sprinkler coverage covers					
	-	t as required by NFPA 13,					
		llation of Sprinkler					
	Systems.	40.050,40.054					
		, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)	17.0	251	KOSA ODDINKI ED OVOTEN		10/00/2024
		on and interview, the facility	K 0	351	K351 – SPRINKLER SYSTEM INSTALLATION		10/08/2024
		y one type of sprinkler head,					
		or standard sprinklers were			What corrective action(s) will	ı	
		etivities office. NFPA 13, 2010 of Sprinkler Systems, Section			be accomplished for those	_	
		quick-response sprinklers are			residents found to have been	n	
		ers within a compartment shall			affected by the deficient		
	_	inless otherwise permitted in			practice? Safe Care came into the		
		tion 8.3.3.4 states when			facility on August 8th, 2024 to		
		d systems are converted to use			measure the replacement spri		
		esidential sprinklers, all			head that was found to be of	IIVICI	
		partmented space shall be			deficient practice in the activity	V	
	-	ient practice could affect at			office. The sprinkler head has	-	
	least 2 staff.	Practice Could affect at			been ordered and is expected		
	1345. 2 54411.				be installed within 4-6 weeks.		
	Findings include:				How will you identify other		
	- mamas meraue.				residents having the potentia	al	
	Based on observation	ons during a tour of the facility			to be affected by the same	w.	
		n 12:45 and 2:15 PM with the			deficient practice and what		
		he Maintenance Director, the			corrective action will be take	n?	

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet Page 3 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155579	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY  COMPLETED  07/24/2024
	PROVIDER OR SUPPLIER		7440 N	ADDRESS, CITY, STATE, ZIP CO N COUNTY ROAD 825 E , IN 47246	D
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5)  ULLD BE PROPRIATE COMPLETION  DATE
	heads. One of the spot to be a quick responsive observed to be a standard. Based on interposervation, the Market observation, the Market observation of the spot o	s equipped with 2 sprinkler prinkler heads was observed has sprinkler head and one was undard response sprinkler rview at the time of hintenance Director agreed has sprinkler head response es office.		All residents residifacility have the potential affected by the alleged of practice.  All rooms, offices, been checked to ensure is not an issue in other a	al to be deficient etc. have that this
	_	viewed with the Administrator irector at the exit conference.		What measures will be place or what systemic changes you will make ensure that the deficien practice does not recur Maintenance staff in-serviced by Administr designee on or before 8 regarding the facility pol procedure "Goals" (Attachich includes making a servicing, repairs, and replacement installation consistent with industry, applicable codes, original and continuity, and Mille Systems requirements.  How the corrective active will be monitored to endeficient practice will recur, i.e., what quality assurance program will into place?  Corrective actions monitored using the QA "Maintenance Review". (Attachment B). This too used to monitor that only of sprinkler head is install each room/office/etc.	to nt r? will be rator or /8/2024 icy and chment A) all s al intent er's Health  ion(s) sure the not ll be put will be tool titled, ol will be y one type

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet Page 4 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155579	B. WI	NG	_	07/24/	/2024
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
				l	COUNTY ROAD 825 E		
MILLER'S	S MERRY MANOR			HOPE,	IN 47246		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	This tool will be used 5x		DATE
					week for 4 weeks, 3x weekly f		
					weeks, 1x week for 4weeks ar		
					monthly thereafter. This QA to		
					will be reviewed as part of the		
					facilities monthly QAPI meetin	_	
					ensure ongoing compliance fo		
					minimum of 6 months and unt		
					facility maintains 95% compliator 6 months.	HUC	
					Tor o montrio.		
K 0353	NFPA 101						
SS=E		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing er and standpipe systems					
	-	sted, and maintained in					
	-	NFPA 25, Standard for the					
		ig, and Maintaining of					
	Water-based Fire	Protection Systems.					
		n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinkler	r system last checked					
	b) Who provided	I system test					
		<u>,</u>					
	c) Water system	supply source					
	Provide in DEMAI	 RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8	•					
	Based on observation	on and interview, the facility	K 0.	353	K353 – SPRINKLER SYSTEM	l <b>–</b>	08/08/2024
		he ceiling construction in the			MAINTENACNCE AND TEST	NG	
		n the kitchen. NFPA 13, 2010			What corrective action(s) wil	I	
		5.5.4 defines a smooth ceiling as			be accomplished for those	_	
		g free from significant s, or indentations. The ceiling			residents found to have been	1	
	-	s, or indentations. The ceiling ses around the sprinkler and			affected by the deficient practice?		
1	I aps not an ana ga	sama ma sprimier and	1		p. 201100 .		1

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet

Page 5 of 10

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY  COMPLETED  07/24/2024	
	ROVIDER OR SUPPLIER		7440 N	ADDRESS, CITY, STATE, ZIP COD I COUNTY ROAD 825 E , IN 47246	
MILLER'S  (X4) ID  PREFIX  TAG	SUMMARY:  (EACH DEFICIEN REGULATORY OR  cause the sprinkler of temperature. Section between the sprinkle above shall be select sprinkler and the type deficient practice of kitchen.  Findings include:  Based on observation the Maintenance Di 12:45 PM and 2:15 observed in the ceil: kitchen mechanical the time of record red Director agreed their aforementioned local measurements.  This finding was recorded.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION To operate at a specified In 8.5.4.1.1 states the distance for deflector and the ceiling ted based on the type of the of construction. This could affect at least 4 staff in the  on with the Administrator and trector on 07/24/20024 between PM, a 2 inch penetration was ting on the left side of the troom. Based on interview at the eview, the Maintenance the was a penetration in the action and provided the  viewed with the Administrator tirector at the exit conference.		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Maintenance has addre and fixed the 2-inch penetration the ceiling that was found to be deficient practice in the kitcher mechanical room.  How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken all residents residing in facility have the potential to be affected by the alleged deficient practice.  All rooms, offices, etc. ceilings have been checked to ensure that this is not an issure other areas.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Maintenance staff will be in-serviced by Administrator of designee on or before 8/8/202 regarding the facility policy are procedure "Goals" (Attachmen which includes maintaining all areas in a like new condition of operation and appearance that the continued inspection and maintenance.  How the corrective action(s)	ssed on in oe of on's  al  en? the e ent  ce in  al  of or cough
				will be monitored to ensure deficient practice will not recur, i.e., what quality	uic

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet

Page 6 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		7440 N	ADDRESS, CITY, STATE, ZIP COD I COUNTY ROAD 825 E IN 47246	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 02	A Life Safety Code Licensure Survey w Department of Heal 483.90(a).  Survey Date: 07/24  Facility Number: 0 Provider Number: AIM Number: 1000 At this Life Safety 0 Manor was found no Requirements for Pactors CFR Subpart 483.90	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000	assurance program will be pinto place? Corrective actions will be monitored using the QA tool to "Maintenance Review". (Attachment B). This tool will used to monitor that all ceiling construction is maintained throughout the facility. This tool will be used 5x week for 4 weeks, 3x weekly weeks, 1x week for 4weeks a monthly thereafter. This QA to will be reviewed as part of the facilities monthly QAPI meeting ensure ongoing compliance for minimum of 6 months and unfacility maintains 95% compliator 6 months.	e itled, be g for 4 nd cool e ng to or a til the

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet

Page 7 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155579	A. BUILDING B. WING	02	COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR		7440 N	ADDRESS, CITY, STATE, ZIP COD  N COUNTY ROAD 825 E  , IN 47246		
(X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and 410 IAC 16.2.  This one story facili Building 01, the ori	ity consists of three buildings. ginal building built in 1973 was Type V (111) construction and			
	was fully sprinklere addition added to th building in 2003 is and was fully sprink	d. Building 02, the 300 Hall e north part of the original of Type V (111) construction clered. Building 01 and eviewed with Chapter 19,			
	main dining room a Building 03 was det and was fully sprink	Therapy, Community Room and ddition constructed in 2019. termined to be of Type V(111) clered. Building 03 was oter 18, New Health Care			
	detection in the corr smoke detectors in	re alarm system with smoke ridor and has battery operated all resident sleeping rooms. spacity of 75 and had a census this survey.			
	were sprinklered. T building providing	dents have customary access the facility has two detached facility maintenance and ich were not sprinklered.			
K 0000	, ,	•			
Bldg. 03	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000		

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet

Page 8 of 10

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED	
		155579	B. W			07/24	07/24/2024	
NAME OF F	AD CAMPED OF CAMPACIEN		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF			7440 N	COUNTY ROAD 825 E			
MILLER'S	S MERRY MANOR			HOPE,	IN 47246			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Dia telike 17		DATE	
	Survey Date: 07/24	4/24						
	Facility Number: 0	000286						
	Provider Number:	155579						
	AIM Number: 100	291000						
	At this Life Safety	Code survey, Miller's Merry						
	1	ot in compliance with						
	_	articipation in Medicare, 42						
	•	0(a), Life Safety from Fire and						
		the National Fire Protection						
		a) 101, Life Safety Code (LSC)						
	and 410 IAC 16.2.							
	This one story facil	ity consists of three buildings.						
	Building 01, the ori	iginal building built in 1973 was						
		Type V (111) construction and						
		ed. Building 02, the 300 Hall						
		ne north part of the original						
	_	of Type V (111) construction klered. Building 01 and						
		eviewed with Chapter 19,						
	Existing Health Car	-						
	_							
	I -	Therapy, Community Room and						
		addition constructed in 2019.						
	_	termined to be of Type V(111)						
		klered. Building 03 was pter 18, New Health Care						
	Occupancies.	pier 10, INCW Health Cale						
	1							
		re alarm system with smoke						
		ridor and has battery operated						
		all resident sleeping rooms.						
	of 36 at the time of	apacity of 75 and had a census						
	of 50 at the time of	uno oui vey.						
	All areas where res	idents have customary access						
	were sprinklered.	The facility has two detached						

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

Event ID:

QWNX21 Facility ID: 000286

If continuation sheet Page 9 of 10

PRINTED: 08/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPLETED		
		155579	B. WI	B. WING			07/24/2024	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				7440 N	ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 825 E IN 47246			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	building providing	facility maintenance and						
	storage services wh	ich were not sprinklered.						
	Quality Review con	npleted on 07/26/24						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QWNX21 Facility ID: 000286 If continuation sheet Page 10 of 10