STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155299	A. BUILDING -- B. WING	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

(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: 02/15/24 Facility Number: 000196 Provider Number: 155299 AIM Number: 100267390 At this Emergency Preparedness survey, Miller's Merry Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 66 certified beds. At the time of the survey, the census was 50. Quality Review completed on 02/19/24	E 0000	This Plan of Correction shall serve as this facility's credible Allegation of Compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve quality of care and comply with all applicable state and federal regulatory requirements. Please consider permitting submission of audit and education as evidence of compliance with state and federal requirements identified in the survey. Respectfully Submitted, Beth Ingram Executive Director	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Ingram	Executive Director	03/04/2024

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	implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C.			

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	552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October			

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	22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/15/24 between 08:55 a.m. and 11:27 a.m., the emergency generator had deficiencies found during the service inspection on April 2023 which needed addressed and fixed as required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the issues with the generator found at the time of the inspection are in the process of getting fixed, but have not been completed yet. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	The Emergency generator was in working condition. Step One: The required service was completed 2/27/2024 Step Two: no other unresolved issues were observed. Step Three: The Maintenance Director was re-educated to the need to review Maintenance reports for issues that require attention. Step Four: The Maintenance Director or his designee will audit every service report weekly for six months. Results will be reported to QAPI monthly, The QAPI Team will make recommendations to amend the Plan of Correction or discontinue audits.	02/27/2024
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/15/24 Facility Number: 000196	K 0000	This Plan of Correction shall serve as this facility's credible Allegation of Compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey	

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	Provider Number: 155299 AIM Number: 100267390 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. It is separated from an attached Assisted Living facility by a Fire Wall with a 2-Hour Fire Resistive Rating. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all 36 resident sleeping rooms. The facility is partially protected by a 150-kW diesel powered generator. The facility has a capacity of 66 beds; 60 are dually certified for Medicare and Medicaid, 6 are certified only for Medicare. It had a census of 50 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/19/24		report. Our Plan of Correction is prepared and executed as a means to continuously improve quality of care and comply with all applicable state and federal regulatory requirements. Please consider permitting submission of audit and education as evidence of compliance with state and federal requirements identified in the survey. Respectfully Submitted, Beth Ingram Executive Director	
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			

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	all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect approximately 30 staff and residents Findings include: Based on an observation during a tour of the facility with the Maintenance Director 02/15/24 between 11:32 a.m. and 12:58 p.m., the corridor leading to the emergency exit near the main nurses station contained a wheelchair scale that took around approximately half of the corridor impeding egress towards the exit. Based on interview at the time of observation, the Maintenance Director confirmed the scale was in the corridor and would relocate the scale. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0211	Step One: The Scale was removed from the hallway Step Two: Remaining hallways were checked and no obstructions were observed Step Three: All staff were re-educated of the need to keep egress hallways clear of obstructions Step Four: The Administrator or her Designee will audit all egress hallways week 1-4 then 8 weeks 5-8, then 6 weeks 9-13, then 4 weeks 14-18, then 3 weeks 19-24. results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audits.	02/27/2024
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lights were maintained in accordance with LSC 7.9.	K 0291	The emergency lighting functioned on all previous checks. Step One: The Battery was	02/27/2024

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	LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect approximately all residents and staff. Findings include: Based on observation with the Maintenance Director on 02/15/24 between 11:32 a.m. and 12:58 p.m., the battery-operated emergency light for the generator would not illuminate when pressing the test button approximately three times. Based on interview at the time of observation, the Maintenance Director confirmed that the light would not illuminate and further stated that the battery may have been dead. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		replaced and the light functioned Step Two: No other battery operated lights were found to have issues. Step Three: Maintenance was re-educated to the need to assure emergency lighting functions properly Step Four: The Maintenance Director or his Designee will audit the battery powered emergency light monthly for six months. results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audits.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20			

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	minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 2 of 36 resident room doors. This deficient practice could affect approximately 5 residents and staff.	K 0363	Step One: The obstructions were removed from the hallway doors. Step Two: All other doors were checked and no obstructions were found. Step Three: All staff were	02/26/2024

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	Findings include: Based on observation with the Maintenance Director on 02/15/24 between 11:32 a.m. and 12:58 p.m., the doors to resident rooms 206 and 312 both had trash cans in front of the door which would impede closing of the door. Based on interview at the time of observations, the Maintenance Director confirmed the trash cans were in front of the door and both cans were removed away from the door upon observations. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		re-educated to the need keep doors free of obstructions. Step Four: The Maintenance Director or his Designee will audit 10 doors week 1-4 then 8 weeks 5-8, then 6 weeks 9-13, then 4 weeks 14-18, then 3 weeks 19-24. results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audits.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility.	K 0712	Step One: The February drill was held on 2/23/2024. The 2024 fire drills were planned out so that the dates are varied. Step Two: No other drills were found to be out of compliance.	02/27/2024

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	Findings include: Based on record review and interview with the Maintenance Director on 02/15/24 between 08:55 a.m. and 11:27 a.m., 7 of 12 quarterly fire drills were conducted near the end of the month, between the 27th and 29th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. Based on interview at the time of record review, the Maintenance Director stated that he makes sure to keep track on the times of day he conducts the fire drills, but doesn't look into which days exactly they are conducted. He further acknowledged that there were multiple fire drills conducted within that short time period. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 3.1-51(c)		Step Three: The Maintenance Director was re-educated to the need to vary the dates of fire drills to prevent staff from anticipating drills. Step Four: The Administrator or her Designee will audit monthly fire drills for six months to assure The date is varied. Results will be reported to QAPI monthly. the QAPI team will make recommendations to amend the Plan of Correction or discontinue audits.	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection	K 0761	Step One: Repairs were requested immediately after the January service inspection noted the gap. the repair will be completed 4/8/2024 Step Two: No other rolling door exists in the building that required repair Step Three: The Maintenance Director was re-educated to the need to follow up on repair needs following an inspection. Step Four: The Maintenance Director or his designee will audit	04/08/2024

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	by the AHJ. This deficient practice could affect approximately all staff and residents within the area of the dining room and kitchen area. Findings include: Based on record review with the Maintenance Director on 02/15/24 between 08:55 a.m. and 11:27 a.m., the rolling fire door inspection titled "Doors: Roll Door Inspection" dated 01/08/24, the rolling fire door for the kitchen had failed its visual inspection. According to the report, it was stated that there was a "gap between right corner of roll door and counter." Based on observation during a tour with the Maintenance Director between 11:32 a.m. and 12:58 p.m., an approximate 1/4" gap was noted on the bottom right corner of the rolling door of the pass-thru window between the kitchen and dining room. Based on interview at the time of observation, the Maintenance Director confirmed that there was an issue with the fire door inspection and that repairs are supposed to be made within the next couple of weeks. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		the condition of the rolling fire door monthly for six months following the repair. Results will be reported to QAPI monthly, The QAPI Team will make recommendations to amend the Plan of Correction or discontinue audits.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/15/24 between 08:55 a.m. and 11:27 a.m., the Generator Maintenance Report from 04/26/23 stated "RADIATOR NEEDS DEGREASED. low oil switch leaking/ 8 door clips, FAN BELTS CRACKED." During interview with	K 0918	Step One: Service was completed 2/27/24 Step Two: no other service required follow up Step Three: The Maintenance Director was re-educated to the need to assure that all service identified in a scheduled inspection is completed timely Step Four: The Maintenance Director or his designee will audit every service report weekly for six months. Results will be reported	02/27/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Maintenance Director, they stated they were aware of the report and parts have been ordered, however due to temperature constraints, the repairs need to be made during warmer weather. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		to QAPI monthly, The QAPI Team will make recommendations to amend the Plan of Correction or discontinue audits.	