STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155574	A. BUILDING -- B. WING	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

(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: 01/21/25 Facility Number: 000431 Provider Number: 155574 AIM Number: 100290380 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 107 certified beds. At the time of the survey, the census was 42. Quality Review conducted on 01/28/25	E 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. Plan of Correction is prepared and executed solely because it is required by the position of the State Law. The Plan of Correction is submitted in order to respond to the annual Life Safety survey January 21, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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: 01/21/25 Facility Number: 000431 Provider Number: 155574 AIM Number: 100290380 At this Life Safety Code survey, Miller's Merry	K 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. Plan of Correction is prepared and executed solely because it is required by the position of the State Law. The Plan of Correction is submitted in order to respond to the annual Life	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rayne Wise	Administrator	02/20/2025

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	155574	A. BUILDING 01 B. WING	01/21/2025

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	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. Building 01 is a one story facility determined to be of Type V (111) construction and was fully sprinklered. Building 02 is a one story extended Therapy room determined to be of Type V (111). The facility has a fire alarm system with automatic smoke detection in the corridors and in areas open to the corridors. All 63 resident rooms were provided with battery operated smoke detectors. The facility is fully protected by a 100 kW diesel powered generator. The facility has a capacity of 107 and had a census of 42 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. Quality Review conducted on 01/28/25		Safety survey January 21, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to maintain the means of egress through 1 of 8 exit egresses in accordance with LSC section 7.2.1.4.1 Swinging-Type Door Assembly Requirement states any door assembly in a means of egress shall be of the side-hinged or pivoted-swinging type, and shall be installed to be capable of swinging from any position to the	K 0211	K211 Means of Egress-General 1.) Deficient fire safety feature. On 1/21/25 during the life safety survey Exit Door #7 did not open when tested. The sidewalk rose up to the low temperatures and blocked the door from opening. 2.) Related fire safety features.	01/22/2025

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	full required width of the opening in which it is installed. This deficient practice could affect 25 residents in the 200-hall. Findings include: Based on observation with the Maintenance Director #1 and Maintenance Director #2 on 01/21/25 at 12:10 p.m., exit door #7 did not open when tested. The sidewalk rose up due to the low temperatures and blocked the door from opening. Maintenance was able to grind the sidewalk down and the door fully opened. The 200-hall did have another exit to the right therefore not making it a dead-end corridor. Based on an interview at the time of observation, the Maintenance Director stated all exit doors are tested weekly but due to the subzero temperatures the sidewalk was pushed up by frost blocking the door from opening. This finding was reviewed with the Administrator and Maintenance Directors #1 and #2 during the exit conference. 3.1-19(b)		Maintenance Director immediately grinded down the sidewalk and the door was able to be opened. All other doors were tested and no other impediments were noted. 3). Measures to ensure deficiency does not reoccur. Maintenance Director will monitor doors weekly in TELS to ensure that the doors are operating appropriately. If subzero temperatures are present in our area, Maintenance Director all leadership will complete rounds daily for 4 weeks, and 1 a week following, then as temperatures are subzero to ensure that there is no other deficient practice of exit doors not opening. Any issues will be addressed immediately. 4). Quality assurance program. All documentation will be presented to the QAPI committee monthly for ongoing review. 5). Plan of correction completion date. Correction was completed immediately on 1/21/25, audits began on 1/22/25, by Maintenance Director/or Designee and will be ongoing.	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Based on observation and interview, the facility	K 0223		01/22/2025

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	failed to ensure 1 of 2 kitchen smoke barrier doors are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 30 residents in the main dining room. Findings include: Based on observation with the Maintenance Director #1 and Maintenance Director #2 on 01/21/25 at 12:20 p.m., the kitchen smoke barrier door to the dining room was propped open with a door wedge from the front that did not release with the fire alarm. Based on an interview at the time of observation, Maintenance Directors #1 and #2 stated the kitchen door was part of the smoke barrier wall and would not close unless the doorstop was moved first. This finding was reviewed with the Administrator and Maintenance Directors #1 and #2 during the exit conference. 3.1-19(b)		K223 Doors with Self-Closing Devices 1.) Deficient fire safety feature. The facility failed to ensure 1 of 2 kitchen smoke barrier doors are self-closing and kept in the closed position. The kitchen smoke barrier door to the dining room was propped open with a wedge. 2.) Related fire safety features. All other doors were reviewed by Maintenance Director and no other impediments were noted. Wedge was immediately thrown away in that was used in the dining room and dietary kitchen to hold door open. 3.) Measures to ensure deficiency does not reoccur. Education to all staff was started immediately to educate them on not using any wedge or other object to prop open a door. and education on not blocking smoke barrier doors. Any obstructions to hold open doors will be removed immediately and education to the staff member will follow. Maintenance Director and all leadership will complete rounds daily for 4 weeks, and 1 a week following, to ensure that there is no other deficient practice of using wedges in the building. 4.) Quality assurance program. All documentation will be presented to the QAPI committee monthly for ongoing review. 5.) Plan of correction completion date.	

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			Correction was completed immediately on 1/21/25, audits began on 1/22/25, by Maintenance Director/or Designee and will be ongoing.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 3 100-hall storage rooms which were a hazardous area containing combustible storage and greater than 50 square feet were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director #1 and Maintenance Director #2 on 01/21/25 at 12:10 p.m., room 117 was used to store large amounts of combustible holiday decorations and was greater than 50 square feet therefore making this a hazardous area. The door to the room was equipped with a self-closing device, but the door did not latch into the frame due to tape over the latching device. Based on interview at the time of observation, Maintenance Director # 2 agreed the room was used as storage, was larger than 50 square feet, and removed the tape from the latching device. This finding was reviewed with the Administrator and Maintenance Directors #1 and #2 during the exit conference.	K 0321	K321 Hazardous Area- Enclosure 1.) Deficient fire safety feature. The facility failed to ensure that the corridor doors to 1 of 3 rooms in hallway 100 that has a self-closing automatic door device would latch by due to putting tape over the latch. 2.) Related fire safety features. All other doors were reviewed by Maintenance Director and no other impediments were noted. Tape on latch was immediately thrown away to keep the latch from closing. 3.) Measures to ensure deficiency does not reoccur. Education to all staff was started immediately to educate them on not using tape on latching doors, education started to all staff. Any tape to hold prevent door latches from closing will be removed immediately and education to the staff member will follow. Maintenance Director and all leadership will complete rounds daily for 4 weeks, and 1 a week following, to ensure that there is	01/22/2025

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	3.1-19(b)		no other deficient practice of using tape in the building. 4.) Quality assurance program. All documentation will be presented to the QAPI committee monthly and ongoing review. 5.) Plan of correction completion date. Correction was completed immediately on 1/21/25, audits began on 1/22/25, by Maintenance Director/or Designee and will be ongoing.	