STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155564	A. BUILDING -- B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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: 01/31/23 Facility Number: 000398 Provider Number: 155564 AIM Number: 100291110 At this Emergency Preparedness survey, Miller's Merry Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 98 certified beds. At the time of the survey, the census was 55. Quality Review completed on 02/01/23	E 0000	*Please accept this Plan of Correction for the Life Safety Code Recertification and State Licensure Survey ending January 31, 2023 as the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction, with a completion date of February 1, 2023. Completed audit tools, corresponding photos, and inservicing have been attached to initiate a desk review for paper 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: 01/31/23 Facility Number: 000398 Provider Number: 155564 AIM Number: 100291110 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with	K 0000	*Please accept this Plan of Correction for the Life Safety Code Recertification and State Licensure Survey ending January 31, 2023 as the Provider's Letter of Credible Allegation of Compliance. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction, with a completion date of February 1, 2023. Completed audit tools,*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Peterson	Executive Director	02/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 98 and had a census of 55 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/01/23		*corresponding photos, and inservicing have been attached to initiate a desk review for paper compliance.*	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress exit by the laundry room was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a tour of the facility with the Executive Director and Maintenance Assistant on 01/31/23 between 12:59 p.m. and 1:54 p.m., the exit door near the laundry room, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. Based on interview at the time of observation, the Executive Director agreed the code was not posted at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Assistant at the exit conference. 3.1-19(b)	K 0222	*It is the policy of Miller's Merry Manor, Mooresville to ensure that the means of egress are readily accessible for residents without a clinical diagnosis requiring specialized security measures.* *The means of egress doors near the laundry room were immediately assessed, and signage was placed above the corresponding keypad detailing means of egress (Attachment A), and verified on February 1, 2023.* *All residents have the potential to be affected by this deficient practice. All egress doors have been audited and tested by facility maintenance staff/designee to ensure the means of egress is readily accessible (Attachment C). Any issues with means of egress signage will be addressed immediately upon discovery.* *Maintenance personnel were educated on February 1, 2023, on ensuring that all means of egress information is readily accessible for residents (Attachment D).* *Maintenance Staff/designee will complete the QA Tool titled Life Safety Code Review (Attachment B) to verify that means of egress is accessible to residents and*	02/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
			visitors. This will be completed weekly for 4 weeks, monthly for 3 months, and quarterly thereafter. Any identified trends will be corrected upon discovery, and documented on facility Quality Assurance Performance Improvement (QAPI) tracking log, and reported during the monthly QAPI Committee meeting overseen by the Administrator.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011	K 0324	*It is the policy of Miller's Merry Manor, Mooresville to ensure that kitchen exhaust systems are*	02/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect mostly kitchen staff, plus all residents while in the adjacent dining room. Findings include: Based on record review on 01/31/23 between 10:23 a.m. and 12:59 p.m. with the Maintenance Assistant and Executive Director, inspection documentation available during the past twelve months for the range hood exhaust system cleaning was dated 03/02/22. The next range hood		*inspected semiannually. The last kitchen hood inspection was completed on January 12, 2023. The next kitchen hood inspection is scheduled for June 2023. The facility identified that the previous vendor was not timely with inspections, and recently switched hood inspection companies in January 2023.* *All residents and dietary staff have the potential to be affected by this deficient practice. An audit of the hood inspection system has been completed, and no other issues have been identified (Attachment C). Any issues with hood inspections will be addressed immediately upon discovery.* *To ensure that the deficient practice does not recur, maintenance personnel were educated on February 1, 2023 to visually inspect kitchen hoods monthly, and ensure inspections are completed timely (Attachment D).* *To monitor the corrective actions and ensure the deficient practice will not recur, the Maintenance Director/designee will complete the QA Tool titled Life Safety Code Review (Attachment B). This will be completed weekly for four weeks, monthly for 3 months, and quarterly thereafter. Any identified trends will be corrected upon discovery, and documented on facility Quality Assurance Performance Improvement (QAPI)*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	exhaust system cleaning was dated 01/12/23. There was no range hood exhaust system inspection report available within six months after the 03/02/22 date. Based on interview at the time of record review, the Executive Director said the facility recently changed companies to inspect the range hood exhaust system and the new company inspected the range hood on 01/12/23. This finding was reviewed with the Executive Director and Maintenance Assistant during the exit conference. 3.1-19(b)		*tracking log, and reported during the monthly QAPI Committee meeting overseen by the Administrator.*	
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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	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 alternate power supply was capable of supplying service within 10 seconds for 9 of the past 12 months. Chapter 6.5.3.1 of NFPA 99 states the life safety and equipment branches shall be installed and connected to the alternate source of power specified in 6.4.1.1.4 and 6.4.1.1.5 so that all functions specified herein for the life safety and equipment branches are automatically restored to operation within 10 seconds after interruption of the normal source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 01/31/23 from 10:23 a.m. to 12:59 p.m. with the Maintenance Assistant, the Emergency Generator Monthly Log Sheets were reviewed over the past year and indicated transfer time from normal power to emergency power was 13 seconds for January 2022 through September 2022. The monthly load tests for October, November and December 2022 indicated a transfer time of 4 seconds. Based on interview at the time of record review, the Maintenance Assistant stated a former Maintenance personnel	K 0918	*It is the policy of Miller's Merry Manor, Mooresville to ensure that the alternate power supply is capable of supplying service within 10 seconds. The Emergency Generator Monthly log times for October 2022 – Current remain under 10 seconds for a transfer of power (Attachment E). Any transfer times exceeding 10 seconds will be addressed immediately.* *All residents and staff have the potential to be affected by this deficient practice. An audit of the Monthly Emergency Generator Log has been completed, and no other issues have been identified (Attachment C). Any issues with generator/emergency power inspections will be addressed immediately upon discovery.* *To ensure that the deficient practice does not recur, maintenance personnel were educated on February 1, 2023 to ensure alternate power supply*	02/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING 01 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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
	was documenting the monthly load tests incorrectly and there is no other monthly load documentation to show transfer time within 10 seconds for the aforementioned months. The Maintenance Assistant agreed transfer time for 9 of the last 12 months was over 10 seconds and further stated he has been trained on documenting the generator monthly load tests by Maintenance personnel from a sister facility. This finding was reviewed with the Executive Director and Maintenance Assistant at the exit conference. 3.1-19(b)		*equipment is capable of supplying service within 10 seconds (Attachment D).* *To monitor the corrective actions and ensure the deficient practice will not recur, the Maintenance Director/designee will complete the QA Tool titled Life Safety Code Review (Attachment B). This will be completed monthly for 3 months, and quarterly thereafter. Any identified trends will be corrected upon discovery, and documented on facility Quality Assurance Performance Improvement (QAPI) tracking log, and reported during the monthly QAPI Committee meeting overseen by the Administrator.*	