STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155173	A. BUILDING -- B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	505 N BRADNER AVE MARION, IN 46952

(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: 01/19/2023 Facility Number: 000089 Provider Number: 155173 AIM Number: 100287760 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 a capacity of 176 and had a census of 65 at the time of this survey. Quality Review completed on 01/25/23	E 0000		
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: 01/19/2023 Facility Number: 000089 Provider Number: 155173 AIM Number: 100287760 At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Velasquez	Administrator	02/03/2023

Any defiencystatement 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.

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	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 II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 176 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/25/23			
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 01/19/23 at 12:50 p.m. the facility has a supervised wet sprinkler system with two pressure gauges with a manufacture date of 2017. No recalibration date information was affixed to the sprinkler system gauge. There was an installed date of 02/19/2018 hand written on the face of the gauges. Based on interview at the time of the observation, the Maintenance Director agreed the manufacture date on the gauges was older than five years and there was no documenation of calibration to verify the gauges were calibrted when installed. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b)	K 0353	**K 353 Sprinkler System-Maintenance and testing.** **It is the policy of Miller's Merry Manor to replace sprinkler gauges every five years or test the sprinkler gauges every five years by comparison with calibrated gauge.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Two sprinkler gauges were manufactured in 2017 and installed on 2/19/2018 during the life safety code inspection. The Facility has contacted a vendor to install two new sprinkler gauges and the vendor is scheduled to replace these two gauges on or around 2/14/23. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents had the potential to be affected. The facility has contacted a vendor to install two new sprinkler gauges on or around 2/14/23. **What measures will be put into place and what systemic changes will be made to**	02/18/2023

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			ensure that the deficient practice does not recur. Once the new Sprinkler Gauges are installed by a vendor, the facility maintenance staff will verify with the vendor the two new sprinkler gauges are in good working order and will keep track of when the five year replacement date. Facility Maintenance director and/or designee will schedule a vendor to replace the gauges before the five years timeframe. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** The facility maintenance director or designee will check the sprinkler gauges at the time of install to insure proper function. The facility maintenance director will then check both newly installed Sprinkler gauges once a week for six months, then monthly thereafter by using the QAPI Maintenance Life Safety Code tool (Attachment A). Any problems or errors identified will be corrected and the error will be placed on an QAPI action plan (Attachment B) and presented at the next QAPI meeting. **By what date the system changes for the deficiency will be completed? 2/18/23.**	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 4 of 4 power strips for non-PCREE (patient-care-related electrical equipment) in resident rooms (outside of resident care vicinity) meet UL 1363. This deficient practice affects eight residents. Findings include: Based on observation with the Maintenance Director and Administratoron 01/19/23 between 12:10 p.m. and 12:35 p.m., in resident rooms 140,	K 0920	**K 920. Electrical equipment – power cords and extension cords.** **It is the policy of Miller's Merry Manor to use power strips in a patient care vicinity are only used for components of movable patient care related electrical equipment assembles that have been assembled by qualified personnel and meet the**	02/18/2023

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	150, 189, and 196, there were power strips in use outside of the resident care area that did not meet UL-1363. Based on interview at the time of observation, the Maintenance Director and Adminstrator agreed power strips were in use in a resident rooms that did not meet UL-1363. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**conditions of 10.2.3.6. Power strips for non-PCREE in the patient care rooms (outside vicinity) meet UL 1363A.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility maintenance director and/or designee replaced the current power strips that were used outside vicinity, with the UL1363 power strips of rooms 140,150,189, and 196. The facility maintenance director completed an audit of all resident rooms in facility to identify any non UL 1363 rated surge protectors (Attachment C Facility Layout). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** There were six residents of the four rooms, where a surge protector was not 1363 rated, outside vicinity, were affected. The four rooms in which surge protectors not having a UL 1363A were replaced by facility maintenance staff. The facility maintenance director completed an audit of all resident rooms in facility to identify any non-UL 1363 rated surge protectors. (Attachment C Facility Layout). The facility has ordered UL 1363 rated surge	

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			protector to replace surge protectors that did not meet the UL 1363 rating and will be replaced by 2/18/23. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The facility maintenance director and or designee will complete a room to room audit (Attachment C facility layout) to look for surge protectors, used outside vicinity that do not meet the UL 1363A rating. Those identified will be replaced with the UL 1363A surge protector. Staff will be in-serviced on differences of surge protectors with UL 1363 and UL 60617 and how/where they should be used in resident rooms. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** The facility maintenance director and or designee completed a resident room audit to identify any surge protectors, that are located outside vicinity, that are not UL 1363A rated. The facility maintenance director and or designee will complete an audit of all residents rooms once a month for a total of 12 months and then monthly thereafter, by using the facility layout (Attachment C) any	

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			identified concerns will corrected then logged on the QAPI action log (attachment B) and reviewed at the next QAPI meeting. **By what date the system changes for the deficiency will be completed? 2/18/23.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as			

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	a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Administrator on 01/19/23 at 12:50 p..m., the oxygen storage room contained three racks that did not separate full oxygen cylinders from empty oxygen cylinders. There was not a designated empty cylinder area identified with a sign, posted in the oxygen storage room. Based on interview at the time of observation, the Maintenance Director stated the cylinders in the racks were full but it could not be verified that the cylinders were full or empty by observation. The findings were reviewed with the	K 0923	**K 923 Gas equipment – Cylinder and container storage…….** **It is the policy of Miller's Merry Manor to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The oxygen storage room is located on a hall that is not used for resident care at this time. Up to 20 residents in one smoke compartment could have been affected. All E Cylinders were removed from the oxygen room on 2/2/23 by an oxygen vendor. **How other residents having the potential to be affected by the**	02/18/2023

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	Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**same deficient practice will be identified and what corrective actions will be taken?** Up to 20 residents in one smoke compartment could have been affected. All oxygen e cylinders were secured upright with a chain surrounding all E cylinders. All E Cylinders were removed from the Oxygen room on 2/2/23 by an oxygen vendor. Removing all E cylinders from the oxygen room mitigated the potential of affecting other residents in the facility. Two signs were ordered, with one sign reading Empty Cylinders and the other sign reading full cylinders. The facility maintenance director and/or designee will install the signs in the Oxygen room once upon arrival. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Two signs were ordered, with one sign reading Empty cylinders and the other sign reads Full cylinders. These two signs will be installed inside the oxygen room once received. Facility staff will be in-serviced on the new signage in the oxygen room and the process to separate empty from partial or full E cylinders by 2/18/23. The facility maintenance director and/or designee will complete an audit of the oxygen room to make	

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			sure empty cylinders are segregated away from cylinders containing partial or full oxygen (Attachment A QAPI Life Safety Code). This will be completed five times each week for a total of six months then 3 times per week monthly thereafter until the facility reaches 95% compliance and the QAPI team determines if any changes are needed. **How the corrective actions will be monitored to ensure the deficient practice will not recur (what QAPI program)** The facility maintenance director and/or designee will complete an audit (Attachment A QAPI Life Safety Code) of the oxygen room to make sure empty cylinders are segregated away from cylinders containing partial or full oxygen. This will be completed five times each week for a total of 6 months than 3 times per week monthly thereafter until the facility reaches 95% compliance. Any identified areas during the audit will be corrected and written on a QAPI action plan (Attachment B) and reviewed at the next QAPI meeting. **By what date the system changes for the deficiency will be completed? 2/18/23**	