STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	787 N DETROIT ST LAGRANGE, IN 46761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/14/13 Facility Number: 000049 Provider Number: 155118 AIM Number: 100270890 Surveyor: Amy Kelley, Life Safety Code Specialist 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 483.70(a), Life Safety from Fire and the 2000 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detectors in resident rooms 18, 19, 22, 23, 26 and 27	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 787 N DETROIT ST LAGRANGE, IN 46761	

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	on the suite hall. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 100 and had a census of 89 at the time of this survey. All areas providing customary access to the residents were sprinklered. The facility has a detached maintenance shed and a biohazardous waste shed providing facility services that were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 2 soiled linen room corridor doors closed and latched into the door frame. This deficient practice could affect 26 residents in the northwest hall and 19 residents in the southwest hall. Findings includes: Based on observation with the Administrator, Maintenance Supervisor and the Maintenance Assistant on 11/14/13 from 12:10 p.m. to 1:30 p.m., the northeast and the southwest soiled linen rooms were designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the other door was designed to latch into the stationary door. Each door could not latch automatically, and independent of	K010029	All Residents have the potential to be effected by this deficient practice. The maintenance department has removed the manual latching mechanisms into the door frame on both the Northwest and Southwest hallways. This will allow for both doors to work independantly of one another and to latch automatically.	12/14/2013

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	the other door, into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)			

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K010045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb would not leave the area in darkness at 1 of 13 exits. This deficient practice could affect any of the nineteen residents evacuated through the Southwest lounge exit. Finding include: Based on observations with Administrator, Maintenance Supervisor and Maintenance Assistant on 11/14/13 at 1:40 p.m., the exterior exit discharge from the Southwest lounge was equipped with a single light fixture with a single bulb. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K010045	All residents have the potential to be effected by this deficient practice. The maintenance department has installed a second fixture to this exit in order to properly illuminate the exit area when needed in an emergency situation.	12/04/2013

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K010047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit signs on the Southwest C hall lead to an exit door. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect any of the 19 residents on the Southwest hall. Findings include: Based on an observation with the Administrator, Maintenance Supervisor and the Maintenance Assistant on 11/14/13 at 1:15 p.m., the direction arrow for the exit sign above the Southwest C hall fire doors indicated the path of egress on the opposite side of the fire door was to the right or left. The path of egress actually continue straight down the corridor, through the next set of fire doors and then to the right or left through the exit doors. This was acknowledged by the Administrator and Maintenance Supervisor at the time of observation. 3.1-19(b)	K010047	All residents have the potential to be effected by this deficient practice. The maintenance department has corrected this deficiency by covering the arrows on this exit sign with an opaque material that in the event of an emergeny the exit sign will still be able to be seen but the directional arrows will not thereby directing those exiting the facility to continue down the hallway.	12/04/2013

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K010051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview, the facility failed to ensure 12 of 12 smoke detectors in the suite hall were installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 5 residents in the suite hall. Findings include:	K010051	All residents have the potential to be effected by these deficient practices. All smoke detectors that were found to be to close the the air supply duct work were moved to further than three feet away in order to be compliant with the regulation. All manual fire alarm boxes that were found to be to high were lowered to regulation height.	12/04/2013

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	Based on an observation with the Administrator, Maintenance Supervisor and the Maintenance Assistant on 11/14/13 from 12:00 p.m. to 12:10 p.m., the smoke detectors in all of the suite double rooms were located within three feet of a air supply duct. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 front area manual fire alarm boxes was mounted at the proper height. NFPA 72, National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice could affect 1 or 2 residents in the Community room when accompanied by a family member or a member of the staff. Findings include: Based on observations with the Administrator, Maintenance Supervisor and Maintenance Assistant on 11/14/13 from 2:10 p.m. to 2:15 p.m., the manual fire alarm box in the front office area southwest exit and the Community room			

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	exit measured 56 and three fourths inches from the floor to the bottom of the fire alarm box. Measurements were provided by the Maintenance Supervisor at the time of observations. 3.1-19(b)			

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K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 4 Central hall fire extinguishers was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect any of the 21 residents in the Central hall. Findings include: Based on an observation with the Administrator, Maintenance Supervisor and the Maintenance Assistant on 11/14/13 at 2:30 p.m., access to the Central hall fire extinguisher near the lounge was obstructed by a portable lift. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K010064	All residents have the potential to be effected by this deficient practice. All staff inservices were completed on 11/22/2013 and staff was educated on the policy on not storing equipment in the hallways infront of fire extinguishers, pull stations and fire doors. Storage of the lift will also be in an alternative space in order to prevent this practice from occuring again.	12/04/2013

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K010074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3			
	Based on observation and interview, the facility failed to ensure window curtains in 1 of 1 Director of Social Services office were flame retardant. This deficient practice could affect 1 or 2 residents in the office of the Director of Social Services. Findings include: Based on observations with the Administrator, Maintenance Supervisor and Maintenance Assistant on 11/14/13 at 1:35 p.m., the window curtains in the Director of Social Services office lacked attached documentation confirming they were inherently flame retardant. Based on	K010074	All residents have the potential to be effected by this deficient practice. The maintenance department has removed the window curtains from the social services department thereby eliminating the risk to the facility and correcting the deficient practice.	12/04/2013

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	interview with the Maintenance Supervisor at the time of observation, there was no documentation regarding flame retardancy for these window curtains available for review. 3.1-19(b)			

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K010076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 3 of 4 oxygen cylinders in the oxygen room were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any of the 21 residents in the central hall. Findings include: Based on an observation with the Administrator, Maintenance Supervisor and Maintenance Assistant on 11/14/13 at 1:00 p.m., there were three unsupported "E" cylinders of compressed oxygen in the oxygen storage room. This was acknowledged by the Maintenance Supervisor at the time of observation.	K010076	All residents have the potential to be effected by this deficient practice. The facility will have the contracted oxygen company dispose of two of the E cylinders and the facility will maintain storage of only one cylinder in the oxygn room. That E cylinder will be chained to the wall as required by regulation. Staff were inserviced on 11/22/2013 and educated on the proper storage of the E cylinders in the oxygen room.	12/04/2013

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K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.	K010144	All residents have the potential to be effected by this deficient practice. Herman and Goetz, the contracted generator maintenance company, came to the facility on 11/22/13 and completed the load bank test. Please see attachment A which is the invoice for the comleted load bank test.	12/04/2013

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	Findings include: Based on record review of the "Generator Log" with the Administrator and Maintenance Supervisor on 11/14/13 at 2:55 p.m., the generator test log showed a monthly load test for the past twelve months but the log did not indicate if the diesel generator was exercised under operating conditions, maintaining the minimum exhaust gas temperatures or not less than thirty percent of the EPS nameplate rating at least monthly, for a minimum of thirty minutes. Based on an interview with the Maintenance Supervisor at the time of record review, he believed the generator operated above 30 percent under full load but could not provide documentation and stated the generator has an annual load bank test but the last test was completed by Herman & Goetz on 05/29/12. 3.1-19(b)			

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K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the central hall medicine room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff with access to the central hall medicine room. Findings include: Based on an observation with the Administrator, Maintenance Supervisor and Maintenance Assistant on 11/14/13 at 1:04 p.m., there was an electrical receptacle on the wall within three feet of a sink in the central hall medicine room.	K010147	All residents have the potential to be effected by this deficient practice. The maintenance department has added a GFI outlet to the the outlet by the sink in the med room of the central hallway. This corrects the deficient practice putting the faciltiy in compliance with the regualtion.	12/04/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Power was not interrupted at the receptacle when the test button was pressed on the GFCI testing device. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			