

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155576	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/17/2016
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 0548 S 100 W HARTFORD CITY, IN 47348
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K 0000  Bldg. 01	<p>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).</p> <p>Survey Date: 08/17/16</p> <p>Facility Number: 000289 Provider Number: 155576 AIM Number: 100289460</p> <p>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.</p> <p>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 and areas open to the corridors. The facility has a capacity of 65 and had a census of 51 at the time of this survey.</p> <p>All areas where the residents have</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K 0018 SS=E Bldg. 01	<p>customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 3 of 17 resident room corridor doors on the 200 hall closed and latched into the door frame. This deficient practice could affect any of the 20 residents on the 200 hall.</p> <p>Findings include:</p>	K 0018	<p>Miller's Merry Manor of Hartford City respectfully submitsthe following plan of correction as a credible allegation of compliance to the above mentioned regulation, K 018. It is the policy of Miller's Merry Manor Hartford City to ensure that the doors to all resident rooms will latch in its frame.</p> <p>1.The doors to resident rooms</p>	09/01/2016

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K 0029 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Maintenance Supervisor and the Administrator on 08/17/16 between 10:51 a.m. and 11:23 a.m., the corridor doors to resident rooms 201, 205, and 210 failed to latch into the door frame and took excessive force to close and open. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p>		<p>201, 205, and 210 were modified to properly fit and latch in their frame.</p> <p>2.All residents are at risk to be affected by the deficient practice.</p> <p>3.An environmental walk through was conducted to ensure proper latching of all resident doors.</p> <p>4.The Maintenance Supervisor or designee will be responsible to complete Quality Assurance Tool "Door Maintenance" (Attachment 1) 5x weekly for four weeks and then monthly for three months. The QA team will then determine the appropriate frequency to continue monitoring after analyzing any concerns and improvements. Any issues identified will be corrected and logged on the facility tracking QA log (Attachment 4). The QA tracking log is reviewed monthly in the facility QA meeting to ensure ongoing compliance.</p> <p>5.The changes were made by September 1, 2016.</p>		

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	<p>door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the door to 1 of 1 storage rooms with combustibles measuring over 50 square feet in size was provided with a self-closing device that automatically latched into the frame. This deficient practice could affect up to 25 residents in the small dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor and the Administrator on 08/17/16 at 10:40 p.m., the door to the storage room, which contained combustible storage and measured over 50 square feet in size, located in the small dining room did have a self-closing device but did not automatically latch in to the frame because the latch was a manual slide bolt. Based on interview, this was confirmed by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>	K 0029	<p>Miller's Merry Manor of Hartford City respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, K 029.</p> <p>1.To correct the deficient practice, daily checks are to be conducted on the storage room doors by the Maintenance Supervisor or designee to ensure the manual slide bolt is in position when the door is not in use. Daily checks will be conducted until materials for new doors are delivered and installed.</p> <p>2.All residents, visitors, and staff have the potential to be affected by this deficient practice.</p> <p>3.A systemic change will be made by installing new doors to the storage room and adding automatic closures, which will not require a manual latch bolt to secure the doors. See approved quote (Attachment 3).</p> <p>4.The corrective actions will be monitored by the Maintenance Supervisor or designee. The Quality Assurance Tool "Interior Room Door Inspection" (Attachment 2) will be completed daily until new doors are installed, weekly after doors are installed for four weeks and then monthly for three months. The QA team will then determine the appropriate frequency to continue monitoring after analyzing any concerns and improvements. Any issues identified will be corrected</p>	09/16/2016	

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			and logged on the facility tracking QA log. The QA tracking log is reviewed monthly in the facility QA meeting to ensure ongoing compliance. 5. These changes will be made by September 16, 2016.		