STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS MERRY MANOR	612 E 11TH ST RUSHVILLE, IN 46173

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K 0000 Bldg. 01	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: 06/21/16 Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 98 and had a census of 61 at	K 0000		

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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	the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage buildings which were not sprinkled. Quality Review completed on 06/29/16 - DA			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observations and interview, the facility failed to ensure the smoke barriers in 3 of 3 health care center attic smoke barrier walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an	K 0025	All areas documented were corrected and smoke barrier material and drywall was applied to meet the standard. All residents have the potential to be effected by this deficient practice. An audit was done through the entire building to ensure ceilings were constructed with least a one half hour fire resistance rating and that any area where the smoke barrier had been penetrated had been appropriately filled with a material capable of maintaining the smokeresistance of the smoke barrier or be protected by an	07/21/2016

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	approved device designed for the specific purpose. This deficient practice affects all residents who reside in the health care center portion of the facility. Findings include: Based on observation with the assistant maintenance supervisor on 06/21/16 from 12:10 p.m. to 12:45 p.m., the following attic smoke barriers in the health care portion of the facility had either penetrations not fire stopped or missing drywall; a. The Northwest Center Hall attic smoke barrier wall had a three inch gap around a sprinkler pipe penetration not fire stopped, a three inch circular area of drywall missing, and a one inch wide by four foot long open gap where two pieces of drywall came together. b. The West Hall to Administration Hall attic smoke barrier wall had a two foot by eight inch area of drywall missing on the east side of the smoke barrier wall. c. The West Center attic smoke barrier wall had a four foot by four foot area of drywall missing on both sides of the smoke barrier wall a two inch circular area of drywall missing in the center of the wall, and a two inch open conduit not fire stopped. The Northwest Center Hall, West Hall to Administration Hall and West Center		approved device designed for the specific purpose. To ensure the deficient practice does not recur the Maintenance Director and Assistant Maintenance Director were educated that an inspection must be completed following any work completed by a vendor to ensure that any smoke barriers that are penetrated will be appropriately filled with a material capable of maintaining the smoke resistance of the smoke barrier or by an approved device designed for the specific purpose. Maintenance Director and assistant were educated that "smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems." Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A)	

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	attic smoke barrier walls missing drywall and not properly fire stopped was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/21/16 at 12:55 p.m. 3.1-19(b)			
K 0029 SS=E Bldg. 01	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 door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 15 rooms used to store either combustible material and measured over 50 square feet or soiled linen rooms were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 12 residents who reside on the West Wing South Hall. Findings include:	K 0029	Maintenance Director installed automatic closing latch to correct this deficient practice immediately. This deficient practice could affect 12 residents who reside on the West Wing South Hall but the intervention put into place protects these residents from the deficient practice. Maintenance Supervisor and Assistant Maintenance Supervisor educated that when contents of room are changed to include hazardous material, such as a combustible storage room over 50 square feet, we are to provide	07/12/2016

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	Based on observations during a tour of the facility with the assistant maintenance supervisor on 06/21/16 from 8:10 a.m. to 12:55 p.m., the dietary combustible storage room, which measured sixty square feet and stored twelve shelves of combustible cardboard boxes of dietary supplies, and the West Wing South Hall soiled linen room each had a one inch gap where the self closing devices failed to close and latch the doors in the door frames. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/21/16 at 12:55 p.m. 3.1-19(b)		it with a self closing device which could cause the door to automatically close and latch into the door frame. Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A)	
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on observation and interview, the facility failed to ensure 10 of 10 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a	K 0046	A 90 minute test was performed on all battery back up lights. All residents have the potential to be affected by this deficient practice. Completion of the 90 minute tests, as mentioned above, protects all residents. To ensure that this deficient practice does not recur, a procedure was put in place (Attachment B) to log monthly and annual testing. Maintenance staff were	07/12/2016

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	functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on observation on 06/21/16 during a tour of the facility from 8:10 a.m. to 12:55 p.m. with the assistant maintenance supervisor, the facility had ten battery backup lights located in the corridors throughout the health care portion of the facility. Based on an interview with the assistant maintenance supervisor on 06/21/16 at 9:10 a.m., the facility does not have written documentation of monthly testing of the ten battery backup lights or a ninety minute annual test. The lack of monthly testing and annual ninety minute tests on ten battery backup lights was verified by the assistant maintenance supervisor at the time of interview acknowledged by the administrator at the		inserviced on use ofthis log. An audit will be completed monthly by the Administrator or designee to ensure the new tool is completed accurately and timely and that all concerns are addressed.(Attachment A)	

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	exit conference on 06/21/16 at 12:55 p.m. 3.1-19(b)			
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 3 of over 300 sprinklers covered in paint or corrosion or in the improper orientation. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice affects 2 residents who reside in resident room 38, 2 residents who reside in resident room 30 and 12 residents who reside on the West Wing South Hall. Findings include: Based on observations on 06/21/16 during a tour of the facility from 8:10 a.m. to 12:55 p.m. with the assistant	K 0062	Vendor was called regarding replacing the identified sprinklers and are scheduled. All residents have potential to be affected by this deficient practice. Interventions that have been made eliminate all residents from being affected going forward. All sprinklers in the facility were checked by Maintenance Supervisor and Assistant Maintenance Supervisor and no other sprinklers found covered in corrosion and paint. Maintenance director or designee will conduct audit titled “Sprinkler System” (Attachment C) weekly forone month and monthly thereafter to maintenance system TELS to ensure sprinklers are not covered in corrosion and paint.	07/21/2016

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	maintenance supervisor, resident room 30 sprinkler was covered in white paint and resident room 38 closet upright sprinkler was turned sideways and not in the upright position. Furthermore, the West Wing South Hall outside overhang sprinkler was completely covered in blue corrosion. This was verified by the assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/21/16 at 12:55 p.m. 3.1-19(b)			
K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where			

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	smoking is permitted. 19.7.4 Based on observation, record review, and interview, the facility failed to ensure 1 of 1 area where smoking was provided with a metal self closing containers for discarded smoking material. This deficient practice could affect 10 residents who use the center courtyard smoking location. Findings include: Based on observation on 06/21/16 at 11:30 a.m. with the assistant maintenance supervisor, the center courtyard smoking location was provided with non combustible ashtrays but lacked a metal self closing container for discarded smoking material. This was verified by the assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/21/16 at 12:55 p.m. 3.1-19(b)	K 0066	To immediately correct the deficient practice a metal container with a self closing cover was ordered and will be put in place upon arrival. There were 10 residents that use the center courtyard that have the potential to be affected by this deficient practice. Replacement of the current ashtray with the self closingmetal ashtray will protect all residents. All staff were educatedon NFPA 101 Life Safety Code Standards 197.4. To ensure that thisd eficient practice does not recur a QA Tool will be completed weekly for fourweeks and monthly thereafter.	07/13/2016
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 4 of 58 resident rooms did not use flexible cords or multiplex outlets as a substitute for fixed	K 0147	Maintenance Director immediately removed the power strips and extension cords that were being used for medical equipment from the affected	07/21/2016

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	wiring to provide power for medical equipment electrical devices. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 8 resident in the facility. Findings include: Based on observations on 06/21/16 during a tour of the facility with the assistant maintenance supervisor from 8:10 a.m. to 12:55 p.m., the following resident rooms used power strips to power medical equipment; a. Resident room 34, bed 1 had a nebulizer breathing machine plugged into a power strip extension cord. b. Resident room 35, bed 2 had a thin wire brown extension cord in use to power a nebulizer breathing machine. c. Resident room 36, bed 1 had an oxygen concentrator machine plugged into a power strip extension cord. d. Resident room 40, bed 1 had an oxygen concentrator machine plugged into a power strip extension cord. The above listed resident rooms using extension cords and power strips for medical equipment was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/21/16 at 12:55 p.m.		rooms. This deficient practice affects 8 residents in the facility but the intervention put into place will protect those residents. All staff were educated on NFPA 70, National Electical Code Article 400-8. Maintenance Director/designee will conduct an audit of the facility to ensure that electrical wiring and equipment shall be used in accordance with the National Electrical Code. To ensure that this deficient practice does not recur a QA Tool will be completed daily for thirty days,weekly for three months, and quarterly thereafter. (Attachment A)	

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