

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155581	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/27/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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K010000	<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: 10/27/14</p> <p>Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</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(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</p>	K010000		

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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K010014 SS=C	<p>capacity of 66 and had a census of 51 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance equipment.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide complete documentation for the flame spread rating of interior finish materials installed within exit access ceilings for 3 of 4 corridors throughout the facility. Section 19.3.3.1 requires interior finish shall be in accordance with Section 10.2. Section</p>	K010014	<p>K 014</p> <p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 014. All residents have the potential to be affected by this practice. The Fire Rating and installation</p>	11/26/2014	

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K010025 SS=D	<p>10.2.3.1 states interior wall or ceiling finish Class A, Class B, or Class C, shall be classified based on test results from NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor on 10/27/14 during the tour from 1:40 p.m. to 1:30 p.m., molded plastic ceiling panels were installed along the ceiling in all three corridors entering the resident room pods. Based on record review and interview, with the Administrator and the Maintenance Supervisor, the documentation provide did not state the ceiling tiles were tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in</p>		documentation for flame rating of the ceiling tiles are attached. (Attachment A: Fire Rating and Approval and installation procedures for our Ceilum Ceiling Tiles). To insure that this practice does not reoccur, the Fire Ratings and Approval documentations will be kept in the Facilities Life Safety Code Binder and monitored by Maintenance Supervisor or Designee. All changes will be completed by 11-26-14.				

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	<p>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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 10/27/14 from 1:15 p.m. to 1:18 p.m., there were three unsealed penetrations in the ceiling of the mechanical/water heater room ranging in size from one half inch around the main sprinkler line to one fourth inch around water lines. Based on an interview at the time of observation, the Maintenance Supervisor provided the measurements.</p> <p>3.1-19(b)</p>	K010025	<p>K 025</p> <p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 025. All residents and staff have the potential to be affected by this practice. All three penetrations in the Mechanical/ Water Heater Room have been sealed. This was completed on October 27th, 2014. To insure that there no other penetrations in the ceilings of the facility, the Maintenance Supervisor or designee will monitor 10 rooms per week for 3 months and then 10 rooms monthly after that. (Attachment B: Life Safety Code Ceiling Review). Results will be reviewed by Administrator weekly and by the QA Committee monthly with all deficiencies being fixed immediately. All changes will be completed by 11-26-14.</p>	11/26/2014			

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K010029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 mechanical/water heater rooms, a hazardous area, would self close and latch into the frame. This deficient practice could affect 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 10/27/14 at 1:10 p.m., the</p>	K010029	<p>K 029</p> <p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 029. All residents have the potential to be affected by this practice. Corridor Door entering the Mechanical/ Water Heater room has been shaved down to allow door to self close when fully open. This was completed on October 28th, 2014. Maintenance Supervisor or designee</p>	11/26/2014

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K010048 SS=C	<p>corridor door entering the mechanical/water heater room near the laundry did have a self closing device but when the door was pulled open it caught on an uneven area of the floor leaving the door in the open position. At the time of observation, the Maintenance Supervisor stated the building was constantly shifting and they have had problems with this door in the past.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> </ol>	K010048	<p>will monitor all rooms with self closing device to insure that they are all working properly weekly for 3 months then every month after that. (Attachment C: Life Safety Code Door Review). Results will be monitored by Administrator weekly and by the QA Committee monthly with all deficiencies being fixed immediately. All changes will be completed by 11-26-14.</p> <p>K 048 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 048. All residents and staff have the potential to be affected by this practice. The Fire Disaster Plan has been updated to include (Attachment D: Fire Disaster Plan) (1) Use of Alarms (2) Transmission of alarm to the Fire Department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke department (7) Preparation of floors and building evacuation (8) Extinguishment of fire To insure that this practice does not repeat staff will be In-Serviced November 21, 2014 and the Fire</p>	11/26/2014			

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K010051 SS=D	<p>(8) Extinguishment of fire This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Supervisor on 10/27/14 at 12:29 p.m., the "Fire Disaster Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>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</p>		Disaster Plan will be reviewed by Administrator monthly for a year and updated yearly per regulation. All changes will be completed by 11-26-14.		

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the kitchen break area was 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 was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 10/27/14 at 1:30 p.m., the smoke detector above the kitchen break area was located 12 inches from an air supply duct. The Maintenance Supervisor acknowledged and supplied the measurements at the time of observation.</p>	K010051	<p>K 051 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 051. All kitchen staff has the potential to be affected by this practice. The Smoke Detector above the kitchen break area has been moved to be in compliance with Life Safety Code regulations. This was completed October 29, 2014. (Attachment E: SafeCare Service Call Report) To insure this deficient practice does not repeat maintenance supervisor or designee will monitor smoke detectors weekly for 2 months and monthly there after. Results will be monitored by the Administrator and the Quality Assurance team with deficiencies being corrected immediately. All Changes will be completed by November 26, 2014.</p>	11/26/2014			

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K010144 SS=F	<p>3.1-19(b)</p> <p>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.</p> <p>Based on observation, the facility failed to ensure the alternate source of power from the generator was capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so that, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load within 10 seconds. This deficient practice could affect all occupants in the facility including staff, visitors and residents in that it could not be assured that all residents were safeguarded by the facility with a generator that could</p>	K010144	<p>K 144</p> <p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 144. All residents, staff, and visitors have the potential to be affected by this practice. The batteries were replaced and the generator was fully operational on October 27, 2014 at 4:22 pm ( Attachment H: H and G Service Order Invoice). To insure this deficient practice does not reoccur Maintenance Supervisor will monitor the generator tests weekly. (Attachment F: Emergency Generator Weekly Form) The results will be monitored by the Administrator and the Quality Assurance team with deficiencies being corrected immediately. All changes will be completed by November 26, 2014.</p>	11/26/2014	

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K010147 SS=E	<p>operate under load conditions when needed during a power failure.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Administrator on 10/27/14 from 12:40 p.m. to 12:50 p.m., while attempting to start the generator manually and with the the transfer switch, the generator made a clicking noise and failed to start. Based on an interview with the Maintenance Supervisor at 12:50 p.m., he thought the starter was bad. The Maintenance Supervisor call H &amp; G service to repair the generator. An email was received by this surveyor from the Administrator on 10/27/14 at 3:39 p.m. stating the mechanic from H &amp; G services had arrived at 3:25 p.m. and found the batteries were dead. At 4:22 p.m. another email was received stating the batteries had been replaced and the generator was functioning properly.</p> <p>3.1-19(b)</p> <p>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 multiplug</p>	K010147	K 147	11/26/2014			

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	<p>adaptor was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 10/27/14 at 1:20 p.m., a multiplug adapter was plugged in and providing power to two gas fueled water heater controllers and one water softener in the mechanical/water heater room. Based on an interview with the Maintenance Supervisor at the time of observation, the adapter did not have an inline fuse for circuit overload protection.</p> <p>3.1-19(b)</p>		<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 147. All residents and staff have the potential to be affected by this practice. Deficient multi-plug adaptor has been removed and an adaptor with an inline fuse for circuit overload protection has been installed. This was completed October 27, 2014. To insure that this practice does not reoccur maintenance supervisor or designee will monitor outlets in 10 rooms weekly for 3 months and 10 rooms monthly there after. (Attachment G: Life Safety Code Outlet Review) The results will be monitored by the administrator and the Quality Assurance team monthly with deficiencies being corrected immediately. All changes will be completed by November 26, 2014</p>				