

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 01/10/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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(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
K0000	<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: 01/10/13</p> <p>Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930</p> <p>Surveyor: Mark Bugni, 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 (111) construction and fully sprinklered. 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</p>	K0000		

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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	<p>portion of the facility has a capacity of 98 and had a census of 79 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the therapy room low point drain closet, and the two detached storage buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/15/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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. 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 and 1 of 11 corridor wall smoke barriers were 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 could affect 48 residents who could use the main dining room, which is located adjacent to the Service Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and administrator on 01/10/13 during a tour of the Service Hall from 9:30 a.m. to 10:40 a.m., the maintenance shop ceiling had a three inch gap around a metal hot water heater exhaust duct penetration and the Service Hall storage room had a one inch gap</p>	K0025	Residents didn't experience a negative outcome from this deficient practice. We placed 5/8 inch thick dry wall over the 3 inch whole located in the maintenance shop. We placed fire stopping material around the ceiling cable penetration to close the one inch gap. We placed a 2x6 along the floor of the wall identified as having missing and crumbling dry wall. To ensure no other residents were affected by the standard identified by the surveyor we completed a detailed inspection of our smoke barriers to establish proper compliance with this life safety code. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues (Attachement A). A work order will be generated if an issue is found and the item will be resolved. This safety code will be revisited monthly as part of the quality assurance meeting. This will occur for the next three	02/09/2013	

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	<p>around a ceiling cable penetration with no firestopping material. Furthermore, the Service Hall corridor wall on the north side of the corridor had a twenty foot by six inch area along the floor wall juncture with missing and crumbling drywall. The maintenance shop ceiling gap around the hot water heater duct penetration, Service hall storage room ceiling gap around the cable bundle, and missing and crumbling drywall along the north wall in the Service Hall were verified by the maintenance supervisor and administrator at the time of observations and confirmed by the administrator at the 2:40 p.m. exit conference on 01/10/13.</p> <p>3.1-19(b)</p>		<p>months and as needed thereafter. All changes will be completed by 2/9/13.</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler low point drain room closets was sprinklered. This deficient practice could affect 8 residents using the therapy room.</p> <p>Findings include:</p> <p>Based on observation on 1/10/13 at 1:40 p.m. with the maintenance supervisor and administrator, the therapy room sprinkler low point drain room closet located in the southwest side of the therapy room was not provided with sprinkler coverage. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator the the 2:40 p.m. exit conference on 1/10/13.</p>	K0056	Residents didn't experience a negative outcome from this deficient practice. We have called Safecare which is our vendor who maintains our sprinkler system. They will be in soon to add a sprinkler line to the identified closet. They will place a sprinkler head on the line so the closet will be sprinklered. To ensure no other residents were affected by the standard identified by the surveyor we checked all other closets to ensure they were sprinklered to establish proper compliance with this life safety code. Compliance of this code will be ensured during preventative maintenance checks identifying possible issues (Attachment A). A work order will be generated if an issue is found and the item will be resolved. This safety code will be revisited monthly as part of the quality	02/09/2013			

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	3.1-19(b) 3.1-19(ff)		assurance meeting. This will occur for the next three months and as needed thereafter. All changes will be completed by 2/9/2013		