

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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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: 06/02/15</p> <p>Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680</p> <p>At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare, 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>The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. A later one story addition, consisting of the east wing constructed prior to March 2003, determined to be Type V (111) was also fully sprinklered, therefore it was</p>	K 0000	<p>K-Tag 025</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure smoke barriers are constructed to provide at least one half hour fire resistance rating.</p> <p>To correct the deficient practice exposed penetrations were sealed with fire rated caulk.</p> <p>All residents can be affected by this deficient practice.</p> <p>To ensure the deficient practice does not recur all building service material were audited to ensure that the space between penetrating items and smoke barrier were filled with a material capable of maintaining smoke resistance. Any areas found to have deficiencies were corrected immediately.</p> <p>The corrective actions will be monitored by the Maintenance Supervisor or designee. The Maintenance Supervisor of designee will complete the Quality</p>	

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>surveyed as one building in accordance with LSC Chapter 19.</p> <p>The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. Battery powered smoke detectors are installed in all resident rooms. The facility has the capacity for 110 and had a census of 82 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached storage sheds in the back of the facility and the vinyl canopy outside the front entrance.</p>		<p>Assessment Tool; "Post Ceiling Penetration Audit" (Attachment 1) will be completed within 24 hours of completion of any work.</p> <p>Date of compliance 6/12/15.</p> <p>K-038</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure that exits access are arranged so that exits are readily accessible at all times.</p> <p>The wet dry shop vac and garden hose were immediately removed.</p> <p>All residents can be affected by this deficient practice.</p> <p>An environmental walkthrough was completed to ensure that all exits were accessible. Any issues were corrected immediately. All staff will be in serviced 6/22/15 on ensuring that exits are not blocked with objects.</p> <p>The corrective compliance will be monitored by the Maintenance Supervisor or designee using the Quality Assessment Tool, "Daily Preventative Maintenance Report" (Attachment 4), will be completed 5</p>	

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			<p>days a week.</p> <p>Date of compliance 6/12/15</p> <p>K-046</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure that emergency lighting is an hour and half duration is provided.</p> <p>Contractor, Circle "R" Mechanical, was hired to install lighting on walkway behind dining room. Installation scheduled for 6/23/15. Contractor H&G confirmed 6/15/15 that lights on the East unit are connected to the generator.</p> <p>Date of compliance 6/23/15</p> <p>K-051</p> <p>It's the policy of Miller's Merry Manor Hobart that fire alarm systems are at permitted height.</p> <p>The fire alarm systems will be moved by SafeCare on 6/22/15</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walk through was conducted to ensure that all fire alarm boxes were at permitted height.</p> <p>Date of compliance 6/22/15</p>	

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			<p>K-054</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure that all smoke detectors are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.</p> <p>A copy of the sensitivity testing for 2013 is attached. (Attachment 2) Smoke detectors were moved out of the 3 feet range or deflectors installed so that there is no air flow interference.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walkthrough was completed on the entire building to ensure compliance.</p> <p>Date of compliance 6/12/15</p> <p>K-062</p> <p>It is the policy of Miller's Merry Manor that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>Escutcheons were replaced and/or installed correctly.</p> <p>All residents are at risk to be affected by the deficient practice.</p>	

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			<p>An environmental walk through was completed to ensure all other escutcheons were installed correctly. Any issues were corrected immediately.</p> <p>Date of compliance 6/12/15</p> <p>K-064</p> <p>It is the policy of Miller's Merry Manor Hobart that all portable fire extinguishers are installed at the appropriate height.</p> <p>Fire extinguishers were lowered to appropriate height.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walk through was conducted to ensure that all fire extinguishers were installed at the appropriate height. Any issues were corrected immediately.</p> <p>Date of compliance 6/15/15</p> <p>K-066</p> <p>It is the policy of Miller's Merry Manor Hobart that no smoking to prohibited on the property.</p> <p>Area was cleaned of cigarette butts.</p> <p>All resident are at risk to be affected</p>	

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			<p>by the deficient practice.</p> <p>An environmental walkthrough was completed to ensure that all areas were cleaned from cigarette butts. Signs were placed on entrances as a reminder to all of the facility policy. All staff will be in serviced 6/22/15 on facility nonsmoking policy.</p> <p>Date of compliance 6/22/15</p> <p>K-076</p> <p>It is the policy of Miller's Merry Manor Hobart that medical gas storage and administration areas are protected.</p> <p>All penetrations were sealed with fire caulk. Chain installed to ensure that oxygen cylinder was secured to the wall.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>The corrective compliance will be monitored by the Maintenance Supervisor or designee using the Quality Assessment Tool, "Daily Preventative Maintenance Report" (Attachment 4), will be completed 5 days a week.</p> <p>Date of compliance 6/12/15</p>		

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			<p>K-130</p> <p>It is the policy of Miller's Merry Manor Hobart to provide complete documentation for preventative maintenance program for battery operated smoke detectors.</p> <p>A detailed form was developed for preventative maintenance on battery operated smoke detectors. (Attachment 3) It includes date, location, test result and plan of action.</p> <p>Date of Compliance 6/12/15</p>	
			<p>K-143</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure oxygen is in a mechanically ventilated, sprinkler head and has ceramic/concrete flooring; separated from where patients are housed by a fire barrier of 1 hour and with signage stating transfer is occurring and no smoking.</p> <p>Exhaust fan was replaced. Door manufacturer was contacted and fire rating documentation provided. (Attachment 5)</p> <p>Oxygen signage was in place but not noticed by the surveyor (Attachment 6)</p> <p>Date of Compliance 6/12/15</p>	

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K 0025 SS=E Bldg. 01	<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 openings through ceiling and wall smoke barriers in 2 of 10 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be</p>	K 0025	<p>K-147</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure electrical wiring and equipment is in compliance.</p> <p>Contractor, Circle "R" Mechanical is installing 15 GFCI receptacles 6/23/15.</p> <p>Date of Compliance 6/23/15</p> <p>K-Tag 025</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure smoke barriers are constructed to provide at least one half hour fire resistance rating.</p> <p>To correct the deficient</p>	06/12/2015

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	<p>protected so that 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 approved device designed for the specific purpose. This deficient practice could affect visitors, staff and 13 residents in service corridor and A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., ceiling and wall penetrations were found:</p> <p>a. Sealed with an unapproved expandable foam around the ceiling duct penetration in the basement storage room;</p> <p>b. In the mechanical room housing the main FACP six by three inch cutout in the ceiling for the passage of pipes were unsealed leaving one inch gaps around the pipes;</p> <p>c. A pipe penetrating the ceiling behind the laundry dryers was unsealed leaving a three quarter inch gap into the space above.</p> <p>The maintenance director acknowledged the unsealed penetration gaps and foam material in use to seal the basement penetration at the time of observations.</p> <p>3.1-19(b)</p>		<p>practice exposed penetrations were sealed with fire rated caulk.</p> <p>All residents can be affected by this deficient practice.</p> <p>To ensure the deficient practice does not recur all building service material were audited to ensure that the space between penetrating items and smoke barrier were filled with a material capable of maintaining smoke resistance. Any areas found to have deficiencies were corrected immediately.</p> <p>The corrective actions will be monitored by the Maintenance Supervisor or designee. The Maintenance Supervisor of designee will complete the Quality Assessment Tool; "Post Ceiling Penetration Audit" (Attachment 1) will be completed within 24 hours of completion of any work.</p> <p>Date of compliance 6/12/15.</p>	

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K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure egress for 1 of 8 exits was arranged to be accessible. LSC 7.1.3.2.3 requires that an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." The exit discharge is the portion of a means of egress between the termination of the exit and a public way. This deficient practice could affect visitors, staff, and 20 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 at 11:55 a.m., the exit discharge path for the main dining room exit was obstructed by an unattended shop wet/dry vacuum and a garden hose which was coiled across the width of the exit discharge path. The maintenance director acknowledged at</p>	K 0038	<p>K-038</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure that exits access are arranged so that exits are readily accessible at all times.</p> <p>The wet dry shop vac and garden hose were immediately removed.</p> <p>All residents can be affected by this deficient practice.</p> <p>An environmental walkthrough was completed to ensure that all exits were accessible. Any issues were corrected immediately. All staff will be in serviced 6/22/15 on ensuring that exits are not blocked with objects.</p> <p>The corrective compliance will be monitored by the Maintenance Supervisor or designee using the Quality Assessment Tool, "Daily Preventative Maintenance Report" (Attachment 4), will be completed 5 days a week.</p> <p>Date of compliance 6/12/15</p>	06/12/2015

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K 0046 SS=E Bldg. 01	<p>the time of observation, the equipment would interfere with the safe and instant use for evacuation in the event of emergency.</p> <p>3.1-(19)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge paths for 2 of 8 emergency exits were provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 20 or more residents on the East wing and main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., the exit discharge for the exit from the east wing near room 137 was provided with emergency generator powered lighting by one exterior single bulb light fixture above the exit alcove and a recessed</p>	K 0046	<p>K-046</p> <p>It's the policy of Miller's Merry Manor Hobart to ensure that emergency lighting is an hour and half duration is provided.</p> <p>Contractor, Circle "R" Mechanical, was hired to install lighting on walkway behind dining room. Installation scheduled for 6/23/15. Contractor H&G confirmed 6/15/15 that lights on the East unit are connected to the generator.</p> <p>Date of compliance 6/23/15</p>	06/23/2015	

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K 0051 SS=F Bldg. 01	<p>single bulb fixture in the exit alcove to illuminate the discharge path. The distance between the point of exit to the public way had no other emergency lighting. Additionally, the exit discharge from the main dining room to the outside had no emergency lighting in the alcove at the point of exit. The maintenance director agreed at the time of observation, these exits were not provided with reliable emergency lighting to illuminate the entire length of their exit discharges.</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 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</p>			

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	<p>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 12 of 19 manual fire alarm boxes were located at the permitted height. NFPA 72, 2-8.1 requires the operable part of each manual fire alarm box shall be not less than 42 inches and not more than 54 inches above floor level. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., manual fire alarm boxes were located higher than the maximum 54 inches allowed. Manual fire alarm boxes located near room 137, near the east unit nurses station, near room 130, outside the business office, at the main dining room exit, at the back exit for the kitchen, and in the kitchen dishwashing room, near the hot water room in the center corridor, near the west unit nurses station, near room 101, at the west lounge exit door, and near the basement storage room were measured at 68 inches above floor level. The maintenance director acknowledged at the time of observations, the manual fire alarm boxes were mount higher than the maximum height permitted by the</p>	K 0051	<p>K-051</p> <p>It's the policy of Miller's Merry Manor Hobart that fire alarm systems are at permitted height.</p> <p>The fire alarm systems will be moved by SafeCare on 6/22/15</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walk through was conducted to ensure that all fire alarm boxes were at permitted height.</p> <p>Date of compliance 6/22/15</p>	06/22/2015			

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K 0054 SS=F Bldg. 01	<p>NFPA 72 fire code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>1. Based on record review and interview, the facility failed to ensure 49 of 74 smoke detectors connected to the fire alarm system had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate that the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where</p>	K 0054	<p>K-054</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure that all smoke detectors are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.</p> <p>A copy of the sensitivity testing for 2013 is attached. (Attachment 2) Smoke detectors were moved out of the 3 feet range or deflectors installed so that there is no air flow interference.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walkthrough was completed on the entire building to ensure compliance.</p>	06/12/2015	

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	<p>nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the facility Smoke Detector Inspection Reports with the</p>		Date of compliance 6/12/15		

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	<p>maintenance director on 06/02/15 at 3:00 p.m., the last record of sensitivity testing was included on a fire system Inspection and Testing Form dated 08/26/14. Sensitivity test results were documented for 25 of the 74 smoke detectors connected to the facility fire alarm system. The maintenance director did not know why and immediately called the testing contractor who explained the 25 detectors tested during an annual fire alarm inspection conducted on 08/26/14 were those that failed a 2013 sensitivity test. A 2013 sensitivity test record was not found and the maintenance director requested an email of the record be sent immediately. No record of a 2013 smoke detector sensitivity test was produced by the conclusion of the survey. The administrator and maintenance director were encouraged to email the missing record to the survey. No sensitivity test record was received as of 06/03/15 at 3:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure smoke detectors providing protection and connected to the fire alarm system was properly separated from an air supply or return vent in 2 of 8 smoke compartments. LSC 9.6.1.4 refers to</p>			

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	<p>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 airflow prevents operation of the detectors. This deficient practice could affect visitors, staff and 10 or more residents on the west unit and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., smoke detectors were not separated from air flow by supply or return air vents which could interfere with their function: in the entry lobby where the smoke detector was eighteen inches from the air vent, in the oxygen supply room where the smoke detector was located ten inches from an exhaust fan, in the DON office where the smoke detector was six inches from an air supply vent, and eight inches from an air vent in the west linen supply room where the baffle installed the prevent air flow from affecting the smoke detector had come apart leaving the smoke detector exposed to air flow from the vent. The maintenance director acknowledged at the time of observations, these smoke detectors could delay alarming if the nearby air vents interfered with the normal flow of</p>						

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K 0062 SS=E Bldg. 01	<p>smoke into their sensing chambers.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation, the facility failed to ensure sprinkler heads providing protection for 1 of 6 smoke compartments were maintained. This deficient practice could visitors, staff, and 20 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., sprinkler head escutcheons were missing and/or improperly installed, leaving gaps of 1/4 to 1 inch into spaces above the ceiling:</p> <p>a. The escutcheon was installed upside</p>			K 0062	<p>K-062</p> <p>It is the policy of Miller's Merry Manor that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>Escutcheons were replaced and/or installed correctly.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walk through was completed to ensure all other escutcheons were installed correctly. Any issues were corrected immediately.</p>		06/12/2015

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K 0064 SS=E Bldg. 01	<p>down for the pendant sprinkler head in the admissions office ante room; b. The sprinkler protecting the janitor's closet in the kitchen had no escutcheon. The maintenance director acknowledged, at the time of observations, installation for these sprinklers were not correctly done.</p> <p>3.1-19(b)</p> <p>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, the facility failed to ensure 12 of 20 portable fire extinguishers were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects 2 or more staff and visitors in the basement and visitors, staff and 40 or more residents on the east, west, and center business smoke compartments.</p> <p>Findings include:</p>	K 0064	<p>Date of compliance 6/12/15</p> <p>K-064</p> <p>It is the policy of Miller's Merry Manor Hobart that all portable fire extinguishers are installed at the appropriate height.</p> <p>Fire extinguishers were lowered to appropriate height.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>An environmental walk through was conducted to ensure that all fire extinguishers were installed at the appropriate height. Any issues were corrected immediately.</p> <p>Date of compliance 6/15/15</p>	06/15/2015			

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K 0066 SS=E Bldg. 01	<p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., portable fire extinguishers were measured higher than the maximum 60 inches above the finished floor in the exit corridor near the business office; three fire extinguishers in the kitchen; in the laundry; near resident rooms 101, 130; near the east nurses station and near physical therapy. The maintenance director acknowledged the location of the fire extinguishers exceeded the maximum height permitted by the Code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where</p>				

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	<p>smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, interview, and record review, the facility failed to provide an enforceable written smoking policy for the protection of 82 of 82 residents. This deficient practice could affect any resident, visitor or staff in the area outside the employee lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 at 12:45 p.m., the grassy and paved areas immediately outside the employee entrance were littered with a carpet of cigarette butts. The maintenance director said at the time of observation the facility did not permit smoking on the property. A review of the facility Tobacco Free Policy with the maintenance director on 06/02/15 at 3:10 p.m., confirmed the tobacco free status of the facility. Guidelines specifically state, "Tobacco products will not be allowed on company property." The guidelines further direct employees to leave the property to smoke. The maintenance director acknowledged the smoking policy was ineffective as evidenced by the</p>	K 0066	<p>K-066</p> <p>It is the policy of Miller's Merry Manor Hobart that no smoking to prohibited on the property.</p> <p>Area was cleaned of cigarette butts.</p> <p>All resident are at risk to be affected by the deficient practice.</p> <p>An environmental walkthrough was completed to ensure that all areas were cleaned from cigarette butts. Signs were placed on entrances as a reminder to all of the facility policy. All staff will be in serviced 6/22/15 on facility nonsmoking policy.</p> <p>Date of compliance 6/22/15</p>	06/22/2015

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K 0076 SS=E Bldg. 01	<p>accumulation of sufficient cigarette butts to carpet the area adjacent to the building.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage room was separated by construction with a one hour fire-resistant rating. NFPA 99, 8-3.1.11.1 requires that storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire-resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects visitors, staff and 20 or more residents in the west unit.</p> <p>Findings include:</p>	K 0076	<p>K-076</p> <p>It is the policy of Miller's Merry Manor Hobart that medical gas storage and administration areas are protected.</p> <p>All penetrations were sealed with fire caulk. Chain installed to ensure that oxygen cylinder was secured to the wall.</p> <p>All residents are at risk to be affected by the deficient practice.</p> <p>The corrective compliance will be monitored by the Maintenance Supervisor or designee using the Quality Assessment Tool, "Daily</p>	06/12/2015

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	<p>Based on observation with the maintenance director on 06/02/15 at 2:10 p.m., four liquid oxygen supply containers and five small oxygen cylinders were stored in a room on the west unit. The maintenance director identified the room as the oxygen supply storage room. A sprinkler pipe penetration was unsealed leaving a half inch gap in the wall and a former plumbing access panel in the ceiling was not sealed at the meeting edge of the wall and ceiling along one side of the former access panel. The maintenance acknowledged at the time of observation, the gaps failed to maintain the one hour fire resistance required for the construction of an oxygen supply storage room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 5 cylinders of nonflammable gases in the oxygen supply storage room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice</p>		<p>Preventative Maintenance Report" (Attachment 4), will be completed 5 days a week.</p> <p>Date of compliance 6/12/15</p>				

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K 0130 SS=E Bldg. 01	<p>could affect visitors, staff and 20 or more residents on the west unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 at 2:10 p.m., one of five oxygen supply cylinders was stored without support in the oxygen supply storage room with four liquid oxygen containers. The maintenance director said at the time of observation, the cylinder should have been secured with the chain provided and in use for the other oxygen cylinders.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and</p>	K 0130	K-130	06/12/2015
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	<p>interview, the facility failed to provide complete documentation of a preventive maintenance program for battery operated smoke detectors installed in 68 of 68 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/14 between 11:30 a.m. and 2:50 p.m., battery operated smoke detectors were installed in the 68 resident sleeping rooms. A review of preventive maintenance records included a computer generated form which noted all battery smoke detectors had been tested monthly. The documentation did not identify the location and test result for each individual smoke detector and its test result. The maintenance director acknowledged at the time of record review, there was no means to ensure each detector had be individually tested or determine whether any smoke detector in any specific location required or had service, cleaning and/or replacement.</p> <p>3.1-19(b)</p>		<p>It is the policy of Miller's Merry Manor Hobart to provide complete documentation for preventative maintenance program for battery operated smoke detectors.</p> <p>A detailed form was developed for preventative maintenance on battery operated smoke detectors. (Attachment 3) It includes date, location, test result and plan of action.</p> <p>Date of Compliance 6/12/15</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was posted with a sign indicating that oxygen transferring was taking place, provided with continuous mechanical ventilation to the outside and separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 20 or more residents on the west unit.</p>	K 0143	<p>K-143</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure oxygen is in a mechanically ventilated, sprinkler head and has ceramic/concrete flooring; separated from where patients are housed by a fire barrier of 1 hour and with signage stating transfer is occurring and no smoking.</p> <p>Exhaust fan was replaced. Door manufacturer was contacted and</p>	06/12/2015

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K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 at 2:10 p.m., four liquid oxygen supply containers and five small oxygen cylinders were stored in a room on the west unit. The maintenance director identified the room as the oxygen supply storage and transfer room. There was no sign to identify the room was used for oxygen transfer. There was no fire rating on the door. A vent in the ceiling was not running. Based on interview at the time of observation, the maintenance director acknowledged continuous mechanical ventilation for the room was not provided.</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</p> <p>1. Based on observation and interview, the facility failed to ensure a wet location for 15 of 18 center hall resident rooms were 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 subject to</p>	K 0147	<p>fire rating documentation provided. (Attachment 5)</p> <p>Oxygen signage was in place but not noticed by the surveyor (Attachment 6)</p> <p>Date of Compliance 6/12/15</p> <p>K-147</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure electrical wiring and equipment is in compliance.</p> <p>Contractor, Circle "R" Mechanical is installing 15 GFCI receptacles</p>	06/23/2015			

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342		
(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	
	<p>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 visitors, staff and 10 or more residents on the center hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 between 11:30 a.m. and 2:50 p.m., electrical outlets in the bathroom serving resident rooms on the center hall were located 18 inches from the sink. No GFCI protection to prevent electric shock was obvious at the receptacles. The maintenance director said at the time of observations the receptacles were connected to GFCI circuits in the electrical panel serving the hall. The circuit panel serving the center hall was checked immediately with the maintenance director. The panel had two GFCI circuits. The legend for the circuits noted the GFCI circuit protected</p>		<p>6/23/15.</p> <p>Date of Compliance 6/23/15</p>		

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	<p>receptacles at the nurses ' station and resident rooms 42, 43, and 44 on the center hall. The maintenance director acknowledged at the time of observation, no circuit panel GFCI was found for the other 15 resident rooms on this hall.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical wiring and equipment in 1 of 6 smoke compartments was in compliance with NFPA 70, National Electrical Code, NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect staff, visitors and 20 or more residents in the laundry smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/02/15 at 1:20 p.m., a four foot length of conduit attached to two junction boxes were located behind the commercial dryers in the laundry. The conduit wound around and rested upon the natural gas supply pipes for the dryers. The conduit had nothing to fasten them securely in place. The maintenance director acknowledged</p>			

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	at the time of observation, the conduit installation had not been secured correctly. 3.1-19(b)				