

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 03/14/2016
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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: 03/14/16</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		
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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>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 79 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>Quality Review completed on 03/16/16 - DA</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</p>				

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	<p>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>1. Based on observation and interview, the facility failed to ensure 1 of 115 resident room doors closed and latched into the door frame. This deficient practice could affect staff and up to 26 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/14/16 at 12:14 p.m., the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the corridor door to resident room 115 failed to latch into the frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Dietary Manager's office corridor door closed and latched into the door frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation and interview on</p>	K 0018	<p>K-Tag 018</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure that the doors to all resident rooms will latch in its frame.</p> <p>The door to resident room 115 and the Dietary Manager's Office door strike was adjusted to ensure proper latching of the door.</p> <p>All residents and staff are at risk to be affected by the deficient practice. An environmental walk through was conducted to ensure proper latching of all resident doors.</p> <p>The maintenance director or other designee will be responsible to perform "Door Maintenance" (Attachment A) weekly for four weeks and then monthly thereafter for ongoing compliance. Any issues identified will be corrected and logged on the facility tracking QA log. The QA tracking log is reviewed monthly in the facility QA meeting to ensure ongoing compliance.</p>	03/30/2016

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K 0022 SS=D Bldg. 01	<p>03/14/16 at 11:25 a.m., the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the corridor door to the Dietary Manager's office had a door stop.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 South West exit discharge sign and 1 of 1 Central exit discharge sign pointed in the direction of the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect could affect staff and at least 52 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor, Maintenance</p>	K 0022	<p>K-Tag 022</p> <p>It is the policy of Miller's Merry Manor Hobart to ensure access to exits are marked and approved, visible signs where the exit or way to reach exit is not apparent to the occupants.</p> <p>The exit signs at the South West and Central exits were removed and replaced to point to the right leading to the public way. Therapy door "no exit" signage was removed.</p> <p>All residents and staff are at risk to be affected by the deficient practice. An environmental walk through was conducted to ensure that doors had proper signage and exit led to public way.</p> <p>The maintenance director or other designee will be responsible to</p>	03/30/2016	

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	<p>#1, and Maintenance #2 on 03/14/16 at 12:08 p.m. then again at 1:26 p.m., the South West exit discharge led to a left or right pathway decision. Then again the Central exit discharge led to a left or right pathway decision. Based on an interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 confirmed both exit discharge should point to the right because the left paths take you back to the facility and not to the public way.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 3 Therapy exit discharge paths was marked with directional indicators to make the direction of travel to reach the public way obvious. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect staff and at least 3 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at</p>		perform "Door Maintenance" (Attachment A) weekly for four weeks and then monthly thereafter for ongoing compliance. Any issues identified will be corrected and logged on the facility tracking QA log. The QA tracking log is reviewed monthly in the facility QA meeting to ensure ongoing compliance.				

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K 0025 SS=D Bldg. 01	<p>1:26 p.m., an exterior Therapy door had a "no exit" sign on the door and an illuminated exit sign above the door. Based on an interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 West Nurse's station corridor 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 could affect staff and at least 2 residents.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K 0025	<p>K-Tag 025 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. To correct the deficient practice exposed penetrations were sealed with fire rated caulk and ceiling tiles were replaced. All residents can be affected by this deficient practice.</p>	03/30/2016

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K 0029 SS=E Bldg. 01	<p>Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 from 11:31 a.m. to 12:49 p.m., the following unsealed corridor penetration and unsealed floor/ceiling penetrations were discovered:</p> <p>a) eight separate half inch corridor penetrations near the West Nurse's station</p> <p>b) one of 117 ceiling tiles was missing under the West Canopy</p> <p>c) four separate ceiling penetrations ranging from one inch to two inches in the Hot Water Room. Then again the floor contained a two inch gap around a water pipe going into the basement.</p> <p>d) one of five ceiling tiles was missing in the Main Janitor's closet</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged and provided the measurements for each unsealed penetration.</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</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 B) will be completed within 24 hours of completion of any work.</p>				

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K 0044 SS=D	<p>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 Medical Records storage room greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 11:55 a.m., the Medical Records storage room contained nine large cardboard boxes containing paperwork and additionally paperwork stacks on top of all metal filing cabinets. There was no self-closing device on the door. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition and confirmed the area contained large amounts of combustible storage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>			K 0029	<p>It is the policy of Miller's Merry Manor Hobart that doors to areas with large amounts of combustible storage are self-closing. To correct the deficient practice a self-closing device was installed on the door. All residents can be affected by this deficient practice.</p> <p>An environmental walk through was conducted to ensure that areas with large amounts of combustible storage had a self closing device installed on the door.</p>		03/30/2016

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Bldg. 01	<p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and at least three residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 11:49 a.m., the fire doors near the West Lounge failed to latch when tested. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p>	K 0044	<p>It is the policy of Miller's MerryManor Hobart to ensure that fire doors are self closing or automatic closing.</p> <p>Fire door outside the West loungesprings were replaced.</p> <p>All residents are at risk to beaffected by the deficient practice.</p> <p>Walk through was completed and therewere no other issues with fire doors closing inappropriately.</p>	03/30/2016			

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K 0051 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector outside resident room 151 was not installed where air flow would adversely affect the operation. 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 could affect staff and up to 26 residents.</p>	K 0051	<p>It's the policy of Miller's Merry Manor Hobart that smokedetectors are installed where air flow does not adversely affect the operation. A deflector was installed on the vent to prevent air flowfrom going towards the smoke detector. All residents are at risk to be affected by the deficientpractice. An environmental walk through was conducted to ensure thatall smoke detectors were not adversely affected by air flow.</p>	03/30/2016	

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K 0052 SS=D Bldg. 01	<p>Findings include: Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 12:55 p.m., the smoke detector outside resident room 151 was twelve inches away from an HVAC return. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 1 of 1 Room 136 smoke detector was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the</p>	K 0052	<p>K-Tag 052 It is the policy of Miller's Merry Manor Hobart to ensure that smoke detectors have approved maintenance and testing sensitivity. The smoke detector ordered and will be replaced by SafeCare by 4/8/16. All residents are at risk to be affected by the deficient practice. Contractor, SafeCare, was inserviced</p>	04/08/2016			

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	<p>second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where 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 any of 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 listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity</p>		that any smoke detectors outside of the sensitivity range needs to alert maintenance and schedule a time to replace				

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K 0062 SS=D Bldg. 01	<p>range shall be cleaned and recalibrated or be replaced. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 10:36 a.m., the most recent documentation of a smoke detector sensitivity test was completed by SafeCare on 08/25/16. Room 136 smoke detector was shown to have a sensitivity range between 1.00 and 2.00. The testing value was indicated at 2.4. Based on an interview at the time of record review, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</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>1. Based on observation and interview, the facility failed to replace 10 of 12 corroded sprinkler heads in the West Canopy. LSC 33.2.3.5.2 refers to LSC</p>	K 0062	It is the policy of Miller's Merry Manor that required automatic sprinkler systems are continuously maintained in reliable operating condition and are	03/30/2016			

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	<p>section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 could affect staff only because it's a staff only entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 11:55 a.m., ten sprinkler heads were corroded under the West Canopy. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 12 sprinkler heads under the West Canopy was maintained. This deficient practice could affect staff only because it's a staff only entrance.</p>				<p>inspected and tested periodically. Escutcheons were replaced and/or installed correctly. All residents are at risk to be affected by the deficient practice. An environmental walk through was completed to ensure all other escutcheons were installed correctly. Any issues were corrected immediately.</p>		

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 11:55 a.m., the West Canopy was missing two escutcheons under the West Canopy. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged both missing escutcheons at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure a 1 of 1 automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect staff only because it's a staff only entrance.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 12:36 p.m., telephone cables were</p>			
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K 0066 SS=D Bldg. 01	<p>wrapped around the sprinkler pipe in the Basement. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</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 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal</p>	K 0066	It is the policy of Miller's Merry Manor Hobart that smoking is prohibited on the property. Area was cleaned of cigarette butts.	03/30/2016

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K 0072 SS=D Bldg. 01	<p>container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only because residents are not allowed to smoke.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 12:56 p.m., there were at least 45 cigarette butts on the ground on the exit discharge from resident room 152. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation, the facility failed to ensure 1 of 1 Basement exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect staff</p>			K 0072	<p>All residents are at risk to be affected by the deficient practice. 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 inserviced 3/23/16 on facility nonsmoking policy. Maintenance will conduct a walking round on the outside of the building weekly to ensure cigarette butts are not on the property.</p> <p>It is the policy of Miller's Merry Manor Hobart that egresses are free of obstructions or impediments in case of fire or other emergencies. All boxes and water jugs were removed from the corridor.</p>		03/30/2016

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K 0130 SS=C Bldg. 01	<p>only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 12:38 p.m., the Basement access corridor had twelve cardboard boxes and fourteen large water jugs. The most restrictive area provided a clear width of twenty four inches and seven eighths inches. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 71 of 71 single station smoke detectors would operate. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor, Maintenance</p>	K 0130	<p>All residents are at risk to be affected by the deficient practice.</p> <p>All corridors were examined to ensure that they were free of obstructions and impediments. Staff were inserviced on 3/23/16 on keeping corridors clear.</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. A detailed form was developed for preventative maintenance on battery operated smoke detectors. (Attachment) It includes date, location, test result and plan of action.</p>	03/30/2016	

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K 0147 SS=E Bldg. 01	<p>#1, and Maintenance #2 on 03/14/16 at 11:18 a.m., the "Smoke-Detector Checklist" failed to include information indicating a battery replacement program for the seventy one single station smoke detectors in resident rooms. Based on interview at the time of record review, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition and confirmed no other documentation is available for review.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 affects staff only.</p> <p>Findings include: Based on observation with Maintenance</p>	K 0147	<p>It is the policy of Miller's Merry Manor Hobart to ensure surge protectors were not used as a substitute for fixed wiring. Refrigerators, microwave and coffee pot were removed from surge protectors and plugged directly into a wall outlet. The outlet in the therapy office cover was replaced. The exposed wiring in the junction box the covers were replaced and the other box was removed. All residents are at risk to be affected by the deficient practice. An environmental walkthrough was conducted of all offices to ensure that devices were plugged directly into wall outlets.</p>	03/30/2016

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	<p>Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 between 11:47 a.m. to 1:18 p.m. the following was discovered:</p> <p>a) a surge protector was powering a refrigerator in the Medical Records office b) a surge protector was powering a microwave in the Activities room c) a surge protector was powering a refrigerator in the Administrator's office d) a surge protector was powering a coffee pot in the Social Service office.</p> <p>Additionally, a surge protector was powering a microwave and a refrigerator. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Therapy MDS office. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Maintenance</p>		<p>Any issues were corrected immediately. All staff were inserviced on Electrical PowerStrip Policy (Attachment C). The Maintenance Director or other designee will be responsible to perform "Equipment Review" (Attachment D) weekly for four weeks and then monthly thereafter for ongoing compliance. Any issues identified will be corrected and logged on the facility tracking QA log. The QA tracking log is reviewed monthly in the facility QA meeting to ensure ongoing compliance.</p>				

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	<p>#1, and Maintenance #2 on 03/14/16 at 1:25 p.m., an outlet was missing a cover in the Therapy MDS office. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 Central Nurse's station fire barrier above the ceiling tile electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance #1, and Maintenance #2 on 03/14/16 at 1:01 p.m., there was exposed wiring in a junction box without a cover in the Central Nurse's station fire barrier above</p>			

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	the ceiling tile. Based on interview at the time of observation, the Maintenance Supervisor, Maintenance #1, and Maintenance #2 acknowledged the aforementioned condition. 3.1-19(b)				