

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155583	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2011
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1367 S RANDOLPH ST GARRETT, IN46738
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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: 11/16/11</p> <p>Facility Number: 000499 Provider Number: 155583 AIM Number: 100266120</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) and 410 IAC 16.2. The original building consisting of the East, West, Back and Center halls and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies.</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>The original one story building was determined to be of Type I (332) construction and fully sprinklered. The new addition was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and sleeping rooms in the Rehabilitation Center. Battery operated smoke detectors are used in the sleeping rooms of the original section of the building. The facility has a capacity of 76 and had a census of 71 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0029 SS=E	<p>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 storage rooms with combustibles measuring over 50 square feet in size was provided with a self closing device. This deficient practice could affect all residents evacuated through the Therapy hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and Administrator on 11/16/11 at 2:12 p.m., the corridor door to the electrical panel room on the Therapy hall, measuring over 50 square feet in size and containing three fifty gallon containers of paper documents for shredding, lacked a self closing device. This</p>	K0029	Safety remains the primary focus for residents and staff of Miller's MerryManor. Stated door to electrical room was fitted with a self closing device on December 2, 2011. Environmental Supervisor is responsible. The Administrator will monitor. Please accept the above POC as our credible Allegation of compliance.	12/02/2011			

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K0038 SS=E	<p>was confirmed by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>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 the means of egress through 4 of 5 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This</p>	K0038	<p>It is the intent of this facility to ensure safety for all residents. In order to ensure egress to all persons desiring same an informational code has been placed at all exits next to code pad. Environmental Supervisor is responsible. Administrator will monitor. Please accept the above POC as our credible Allegation of Compliance.</p>	12/05/2011	

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	<p>deficient practice could affect any resident without a medical diagnoses requiring security measures exiting through all exits except the front entrance.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and the Administrator on 11/16/11 from 1:40 p.m. to 2:55 p.m., all exit doors with the exception of the front entrance were magnetically locked and could be opened by entering a code, but the code was not posted. Based on interview with the Administrator at 1:40 p.m. on 11/16/11, five residents do not have a medical diagnoses requiring security measures.</p> <p>3.1-19(b)</p>				
K0048 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written fire plan that included the proper use of the kitchen fire K class fire</p>	K0048	<p>Safety is the first concern of this facility. The Cooking Bank Fire and Fire Equipment Policy has been changed to the following: Cooking Bank Fire and Fire Equipment Policy1. In the event of fire at the Cooking Bank, the</p>	12/06/2011	

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	<p>extinguisher for the protection of 71 of 71 residents in the event of an emergency. 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"> (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 compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facilities "Disaster Manual" with the Administrator and the Environmental Supervisor on 11/16/11 at 1:30 p.m., in the section titled "Cooking Bank Fire and Fire Equipment," it states employees are to use the K class fire extinguishers on a small fire at the cooking bank. If the fire cannot be quickly extinguished by</p>		<p>Hood System will be the primary fire fighting tool.2. The Cooking Bank Hood System can be manually activated by pulling on the handle/ring which is located next to K Class fire extinguisher at the right of walk-in refrigerator.3. The fire suppression system will automatically activate thru the fusible link that will melt apart at 360 degrees.4. If the buildings fire alarm system has not already been sounded pull the nearest pull station to activate the buildings fire system.5. Follow the Fire System Disaster Plan in the Disaster Manual.Environmental Supervisor is responsible.Administrator will monitor.</p>		

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K0061 SS=E	<p>fire extinguisher then the fire suppression system is to be activated. The proper procedure is to use the fire suppression system first and then the K class fire extinguisher as a secondary means. Based on an interview with the Environmental Supervisor at 2:30 p.m. on 11/16/11, this information was received today.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 water valves for the sprinkler system were electronically supervised. This deficient practice affects all 58 occupants in the original section of the building.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Environmental Supervisor on 11/16/11 at 2:22 p.m., the water shut off valves in the Boiler/sprinkler riser room were</p>	K0061	<p>Safety is our intent for all residents at Miller's Merry Manor. Electronic TamperProof Sprinkler Gate Valve Switchs have been installed per your request. Environmental Supervisor is responsible. Administrator will monitor.</p>	12/07/2011

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K0130 SS=E	<p>secured in the open position with a chain and a padlock, however, there was no electronic supervision for the valves. Based on an interview with the Environmental Supervisor at the time of observation, the valves have always been chained in the open position.</p> <p>3.1-19(b)</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 fire barrier walls was capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.3.1 requires every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other.</p>	K0130	<p>Safety is the primary focus for residents and staff of Miller's Merry Manor. It should be noted here that the crack on the fire barrier was sealed on the oppositeside of where the surveryor inspected, therefore smoke and fire were limited in the spread of same. However per your request fiberglass insulation was removedand the 1/4 inch wide by 4 inch long space was filled with intumescent firestopsealant. Environmental Supervisor is responsible.Administrator will monitor.Please accept the above POC as our credible Allegation of Compliance.</p>	12/07/2011	

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K0000	<p>This deficient practice could affect two of five smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 11/16/11 at 2:45 p.m., the one half inch gap at the top of the east hall fire wall between the wall and the roof decking was stuffed with pieces of fiberglass insulation. Based on interview with the Environmental Supervisor at the time of observation, the wall was a fire barrier wall.</p> <p>3.1-19(b)</p> <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: 11/16/11</p> <p>Facility Number: 000499 Provider Number: 155583 AIM Number: 100266120</p>	K0000			

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	<p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor was found 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) and 410 IAC 16.2. The 2001 Therapy Center was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The original one story building was determined to be of Type I (332) construction and fully sprinklered. The new addition was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and sleeping room in the Rehabilitation Center. Battery operated smoke detectors are used in the sleeping rooms of the original section of the building. The facility has a capacity of 76 and had a census of 71 at the time</p>				

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K0038 SS=E	<p>of this survey.</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 4 of 5 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect any resident without a medical diagnoses requiring security measures exiting through all exits except the front entrance.</p>	K0038	It is the intent of this facility to ensure safety for all residents. In order to ensure egress to all persons desiring same an informational code has been placed at all exits next to code pad. Environmental Supervisor is responsible. Administrator will monitor. Please accept the above POC as our credible Allegation of Compliance.	12/05/2011	

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	<p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and the Administrator on 11/16/11 from 1:40 p.m. to 2:55 p.m., all exit doors with the exception of the front entrance were magnetically locked and could be opened by entering a code, but the code was not posted. Based on interview with the Administrator at 1:40 p.m. on 11/16/11, five residents do not have a medical diagnoses requiring security measures.</p> <p>3.1-19(b)</p>				