STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/21/2011
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN47882	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	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). Survey Date: 10/21/11 Facility Number: 000163 Provider Number: 155262 AIM Number: 100291380 Surveyor: Dennis Austill, Life Safety Code Survey Supervisor 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. This one story facility was determined to be of Type V (000) construction and was fully	K0000	Please see cover letter which was uploaded in supporting documents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 93 and had a census of 86 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/21/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 100 room doors protecting corridor openings prevented the passage of smoke. This deficient practice could affect any resident	K0018	**K 018 NFPA 101 Life Safety Code Standard.** The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned	10/25/2011

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	in the corridor as well as visitors and staff. Findings include: Based on observation on 10/21/11 at 12:40 p.m. with the Maintenance Supervisor, the dry food storage room had a door with a vent through the door. Based on interview at the time of observation, the Maintenance Supervisor indicated the vent had been installed in the door with a fusible link fire damper to help prevent the room from overheating. 3.1-19(b)		regulation, prefix K 018. I. To correct the deficient practice the facility covered the opening on both sides of the fire damper thus making it resistant to the passage of smoke. II. This deficient practice could affect any resident in the corridor as well as visitors and staff. III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Maintenance Supervisor will oversee any changes made to doors protecting corridor openings to ensure they prevent to passage of smoke. IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will ensure doors protecting corridor openings prevent the passage of smoke. V. Maintenance Supervisor will be responsible. Completion Date: 10/25/11.	

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K0029 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 5 room doors serving hazardous areas such as a fuel fired heater room prevented the passage of smoke. This deficient practice could affect any resident in the corridor as well as visitors and staff. Findings include: Based on observation on 10/21/11 at 12:20 p.m. with the Maintenance Supervisor, the electrical room which contained a natural gas water heater had a door with a vent through the door. Based on interview at the time of observation, the Maintenance Supervisor indicated the vent had been installed in the door with a fusible link fire damper to help prevent the room from overheating. 3.1-19(b)	K0029	**K 029 NFPA 101 Life Safety Code Standard.** The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 029. I. To correct the deficient practice the facility removed the fusible link on the fire damper in the electrical room door to ensure it is resistant to smoke. II. This deficient practice could affect any resident in the corridor as well as visitors and staff. III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) The Maintenance Supervisor will ensure doors serving hazardous areas prevent the passage of smoke. IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will ensure hazardous areas are separated from other spaces by smoke resistant partitions and doors. 2) Maintenance Supervisor will oversee and	10/21/2011

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			approve all changes to smoke resistance partitions or doors. V. Maintenance Supervisor will be responsible. Completion Date: 10/21/11.	
K0068 SS=E	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect any resident in the corridor as well as visitors and staff. Findings include: Based on observation on 10/21/11 at 12:20 p.m. with the Maintenance Supervisor, the laundry room had two, gas fueled dryers with no fresh air intake. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the two gas fueled dryers did not have a fresh air intake. 3.1-19(b)	K0068	**K 068 NFPA 101 Life Safety Code Standard.** The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 068. I. To correct the deficient practice the facility installed a fresh air intake in the exterior wall in the laundry room. II. This deficient practice could affect any resident in the corridor as well as visitors and staff. III. The facility has made systemic changes to ensure the deficient practice does not recur by the following: 1) The Maintenance Supervisor will ensure the laundry room, which contains two gas fueled dryers, is provided with makeup combustion air from the outside via the newly installed fresh air intake. 2) The Maintenance Supervisor installed a fresh air intake in the exterior wall of the laundry room on 10/25/11. IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will ensure the fresh air intake remains in place in the laundry room and unobstructed in order to function as a fresh air	10/25/2011

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			intake for the two gas fueled dryers. V. Maintenance Supervisor will be responsible. Completion Date: 10/25/11.	