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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155150 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/22/2014 |
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| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K010000 | <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: 12/22/14</p> <p>Facility Number: 000071 Provider Number: 155150 AIM Number: 100273140</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridor and battery operated smoke detectors in</p> | K010000 | | |

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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| K010056 SS=D | <p>the resident rooms. The facility has a capacity of 84 and had a census of 65 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete</p> | K010056 | K056. On 12/30/14, the | 12/30/2014 |

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| | <p>automatic sprinkler system was provided for 1 of 1 medical records room closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation and interview on 12/22/14 at 12:55 p.m., the Environmental Supervisor and Maintenance Technician #1 confirmed the closet enclosure areas of the medical records room lacked sprinkler coverage. Maintenance Technician #1 stated the built-in attached closet from the closet enclosures was removed and the area was used for additional storage.</p> <p>3.1-19(b)</p> | | <p>Maintenance Technician removed the bulk-head above where the built-in attached closet had previously been taken out. The bulkhead was removed up to the ceiling and a drop ceiling was installed that is the same height as the remaining part of the Medical Records Storage Room ceiling. This will ensure that automatic sprinkler coverage is provided for all portions of this room. The Environmental Services Supervisor and Maintenance Technician have inspected other areas in the facility with built-in attached closets and all of those areas are properly covered by the automatic sprinkler. It will be the responsibility of the Environmental Services Supervisor, in conjunction with the Maintenance Technician and/or Administrator, to ensure that any future renovations calling for the removal of any built-in attached closets will have the bulkhead fully removed to the same height as the existing ceiling in the room. This will provide that all portions of the room will be covered by the automatic sprinkler.</p> <p>12/30/2014</p> <p>The facility submits this information as credible allegations of compliance.</p> | |

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| K010064 SS=B | <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</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 1 fire extinguishers near resident room 26 was secure and properly mounted. NFPA 10, Section 1.6.7 states fire extinguishers shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. This deficient practice could affect 12 residents near resident room 26.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and Maintenance Technician #1 on 12/22/14 at 1:22 p.m., the fire extinguisher placed in the fire extinguisher cabinet near resident room 26 was sitting unsecured on the bottom of the cabinet. The Plexiglas from the door of the cabinet was missing and the fire extinguisher was not securely hung from the wall bracket inside the cabinet. Based on an interview with the Environmental Supervisor at the time of observation, the fire extinguisher was too large and could not be securely hang from the bracket in the fire extinguisher cabinet near resident room 26.</p> | K010064 | <p>K064. On 12/22/14, the Maintenance Technician moved the bracket in the fire extinguisher cabinet/wall recess near resident room 26 on the lower level so that it is now properly secured. All other fire extinguishers were checked and found to be properly mounted in the fire extinguisher cabinet/wall recesses or on the walls. The Fire Extinguisher: Monthly Inspection Form (Please see Attachment LSC-1) now has a section added to check that each extinguisher is properly mounted in the fire extinguisher cabinet/wall recesses on a hanger or bracket. It will be the responsibility of the Environmental Services Supervisor and/or Maintenance Technician to complete the inspection form on a monthly basis to ensure that all fire extinguishers in cabinets/wall recesses are properly mounted. 12/22/2014</p> <p>The facility submits this information as credible allegations of compliance.</p> | 12/22/2014 |

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| K010130 SS=E | <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 2 of 9 fire barrier walls were maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the</p> | K010130 | <p>K130. On 12/26/14, the Maintenance Technician tore out the old expandable foam in the fire wall above the ceiling tile near the lower level main dining room. This area was then filled with intumescent fire caulk. Also on 12/26/14, the Maintenance Technician filled the unsealed penetration of the fire wall near resident room 23 on the lower level with intumescent fire caulk. This area had been previously filled with the intumescent fire caulk, but it appeared the caulk had dried out leaving a gap. The Environmental Services Supervisor and Maintenance Technician checked all other fire wall penetrations and did not find any others unsealed. The Fire Alarm System: Quarterly Fire Door Inspection Form (Please see Attachment LSC-2) now has a section added to check each side of the fire door above the ceiling tile and inspect any fire wall penetration for proper sealing with intumescent caulk. Areas where the caulk has dried out will be replaced and/or added to with intumescent caulk. It will be the responsibility of the</p> | 12/26/2014 |

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| | <p>sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 10 residents in the lower level dining room and 20 residents near resident room 23 in the lower level.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor and Maintenance Technician #1 on 12/22/14 at 1:52 p.m., above the ceiling tile at the fire barrier wall near the lower level main dining room there was a penetration sealed with expandable foam. At 2:05 p.m., above the ceiling tile at the lower level fire barrier wall near resident room 23 there was an unsealed penetration measuring two inches wide around a gas line. Based on an interview with Maintenance Technician #1 at the time of observations, he confirmed the aforementioned walls were concreted fire barrier walls and was unable to provide documentation regarding the expandable</p> | | <p>Environmental Services Supervisor and/or Maintenance Mechanic to complete the inspection form on a quarterly basis to ensure that all fire wall penetrations are properly sealed with intumescent caulk.</p> <p>12/26/2014</p> <p>The facility submits this information as credible allegations of compliance.</p> | |

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| | foam. 3.1-19(b) | | | | |