STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155578	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/28/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 220 E DUNN RD NEW CARLISLE, IN 46552	

(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
K010000	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: 10/28/13 Facility Number: 000527 Provider Number: 155578 AIM Number: 100267110 Surveyor: Phillip Komsiski, Life Safety Code Specialist 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility	K010000	To Whom it May Concern, Please accept the attached CMS-2567 and Plan of Correction of our Life Safety Code survey completed on, October 28, 2013 as our allegation of compliance. The facility respectfully requests paper compliance for this deficient practice. If you have further questions please contact me at 574-654-7244. Sincerely,Jacob Revere	

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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	has a capacity of 70 and had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one garage used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/31/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010038 SS=E	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 Based on observation and interview, the facility failed to ensure exit access discharge was arranged so 1 of 6 exits provided an access path to a public way which could be maintained in inclement weather. LSC Section 7.1 at Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exterior walking surfaces within the exit discharge are not required to be paved and may be provided by grass or similar surfaces. However, where discharging exits into yards, across lawns, or on similar surfaces, in addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect 16 residents on south hall including visitors and staff if the facility were required to evacuate.	K010038	The facility respectfully submits the following Plan of Correction as credible allegation of compliance to the above mentioned regulation, prefix K038. This deficient practice could affect 16 residents on the South Hall including visitors and staff if the facility required to evacuate. To correct this deficiency, a reinforced concrete walkway was installed on 5/11/2013. The side walk connects to the hard surface drive way enabling residents, staff, and visitors to safely exit the facility and area to code. Please see the attached picture of the completed work.	11/05/2013

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	Findings include: Based on observation on 10/28/13 at 1:15 p.m. with the Maintenance Supervisor, the west exit leading out of the Main dining room discharged onto a grass surface which leads to a public way. Based on interview on 10/28/13 at 1:21 p.m. with the Maintenance Supervisor, it was acknowledged the west exit for the Main dining room adjacent to south hall discharged onto a grassy surface. Further interview with the Maintenance Supervisor revealed the grassy surface cannot be maintained during snow or heavy periods of rain. 3.1-19(b)			