

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155102	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563
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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: 01/07-08/16</p> <p>Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400</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 one story facility was determined to be of Type V (000) construction and was fully sprinklered. The building was constructed in three phases: the original building was constructed in 1968 and includes the Terrace wing, ICF I and ICF II; ICF III and the Skilled wing were completed in 1974 with the Orchard wing and Main hall added in 1985. The</p>	K 0000		

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=D Bldg. 01	<p>facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 131 and had a census of 86 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 sheds for facility storage which were not sprinklered.</p> <p>Quality Review completed 01/14 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 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation, the facility failed to ensure 1 of 82 sleeping room doors would close and latch into the door</p>	K 0018	K018 The deficient practice could affect staff and 2 residents. To correct the deficient practice the	02/07/2016

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K 0021 SS=E Bldg. 01	<p>frame. This deficient practice could affect staff and 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 at 10:18 a.m., a couch was in the path of the door swing of resident room #26, preventing the corridor door from being closed. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if</p>		<p>recliner was pushedback in place immediately and maintenance staff ensured door would closeproperly. To ensure the deficient practice does not occur again, allstaff will be in-service on the importance of keep door ways cleared in orderto close and latch to frame by 2/7/16. Life Safety Review will be done by Maintenance Staff ordesignee weekly for four weeks and monthly there after to ensure compliance(Attachment A).</p>				

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K 0025 SS=D Bldg. 01	<p>installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Laundry doors, a hazardous area, was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect at least 18 residents who were in the Dining room at the time of observation.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 at 10:42 a.m., the Laundry door to the corridor was held open by a hood and eye bolt and would not automatically release with activation of the fire alarm. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition and confirmed the dryers were fuel fired.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are</p>	K 0021	<p>K021</p> <p>This deficient practice could have affected 18 residents that were in the Dining room at the time of observation.</p> <p>To correct the deficient practice the hood and eye bolt was removed on 1/8/16 by maintenance staff.</p> <p>To ensure this deficient practice does not occur again, all doors arranged to automatically close upon activation of fire alarm will be checked by maintenance staff to ensure automatic release with activation of fire alarm will be checked by 2/7/16. Results will be documented and any issues will be corrected immediately.</p> <p>Life Safety Review will be done by Maintenance Staff or designee weekly for four weeks and monthly thereafter to ensure compliance (Attachment A).</p>	02/07/2016			

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K 0029 SS=E	<p>protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one 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 only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 2:08 p.m., there was a half inch gap around telephone wire in the North Skilled Attic Access room. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged and provided the measurements for the unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 0025	<p>K025</p> <p>This deficient practice could affect staff in that area.</p> <p>To correct the deficient practice, the ½ inch gap in thenorth skilled Attic access room was properly closed with fire caulk bymaintenance staff.</p> <p>To ensure this deficient practice does not occur again, allareas will be assessed for compliance by maintenance personnel. Maintenance staff will be re-inserviced by corporateEnvironmental Services on importance of working closely with contractors andvendors and to check any work that is done near fire walls for compliance.</p> <p>This will be done by 2/7/16.</p>	02/07/2016

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Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Mechanical room, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 1:29 p.m., the Mechanical room contained fuel fired appliances. The exterior door in the Mechanical room failed to self close and latch when tested. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p>	K 0029	<p>K029</p> <p>This deficient practice has the potential to affect staff in the area.</p> <p>1. To correct the deficient practice, a self closer and latch will be installed on the Mechanical room door by 2/7/16.</p> <p>2. To correct the deficient practice, all three doors in question had automatic closers installed on them by facility maintenance staff.</p> <p>3. To correct the deficient practice, a self closer will be installed on the kitchen door by 2/7/16.</p> <p>To ensure these deficient practices do not occur again, all potentially hazardous areas were assessed for need of automatic door closure and no other areas identified.</p>	02/07/2016

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 2 of 2 storage room greater than 50 square feet, a hazardous area, was provided with self closer and would latch into the frame. These deficient practices were not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 between 2:51 p.m. and 2:56 p.m. the following was discovered:</p> <p>a. the Service Director office contained at least 30 cardboard boxes, at least 40 binders containing paper, and many pieces of paper laying over furniture. The door to the Service Director office failed to self close and latch when tested.</p> <p>b. Room 62 contained at least 32 cardboard boxes, 2 beds with mattresses, and four nightstands. Room 62 failed to self close and latch when tested.</p> <p>c. Room 67 contained 11 mattresses, 12 cardboard boxes. Room 67 failed to self close and latch when tested.</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor and Maintenance Assistant</p>			

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K 0039 SS=E Bldg. 01	<p>acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 5 Kitchen doors, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 at 10:29 a.m., the Kitchen exterior door failed to self close and latch when tested. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p>			

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K 0044 SS=E Bldg. 01	<p>Based on observation and interview, the facility failed to ensure 1 of 11 exit access corridors was maintained with clear and unobstructed width of at least four feet at all times. This deficient practice could affect staff and up to 14 residents.</p> <p>Findings include: Based on an observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 2:03 p.m., a large scale was in the corridor to the Skilled North exterior exit. The scale and a piece of furniture caused the corridor's clear width to be 42.5 inches. Based on an interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 11 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</p>	K 0039	<p>K039</p> <p>This deficient practice has the potential to affect staff and up to 14 patients.</p> <p>To correct this deficient practice, the scale and chair were removed to a new location on 1/7/16.</p> <p>To ensure the deficient practice does not occur again, all staff will be in-service on the importance of keeping exits cleared by 2/7/16. Life Safety Review will be done by Maintenance Staff or designee weekly for four weeks and monthly thereafter to ensure compliance (Attachment A).</p>	02/07/2016
		K 0044	<p>K044</p> <p>This deficient practice has the potential to affect up to 24 patients.</p> <p>To correct this deficient practice, The Terrace doors will have latching hardware installed on them by 2/7/16 by facility vendor.</p> <p>To ensure this deficient practice</p>	02/07/2016

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K 0048 SS=E Bldg. 01	<p>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 up to 24 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 3:12 p.m., the Terrace fire doors did not have latching hardware. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review, observation, and interview, the facility failed to provide a written plan that included the evacuation</p>	K 0048	<p>does not occur again, maintenance staff will check other sets of fire doors for latching hardware to ensure compliance. Audit summary will be documented by facility maintenance staff by 2/7/16.</p> <p>K048 This deficient practice could affect all staff, visitors, and up to 18 patients. To correct this</p>	02/07/2016

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	<p>of smoke compartments in the facility in 1 of 1 written fire plans. 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 staff, visitors, and up to 18 residents.</p> <p>Findings include:</p> <p>Based on a record review on 01/07/16 between 10:34 a.m. to 12:40 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a fire barrier. Based on observation and interview, there were two sets fire doors that the Maintenance Director confirmed were not fire barriers and could be confused as a fire barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the policy did not indicate which doors were not considered fire doors and acknowledged the</p>		<p>deficient practice, the written fire plan was updated to include clear markings of location of fire doors. (Attachment B). To ensure this deficient practice does not happen again, all staff will be in serviced on location of fire doors by 2/7/16.</p>	

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K 0050 SS=C Bldg. 01	<p>aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Fire & Evacuation Drill/Event Form" forms with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 11:09 a.m., four sequential third shift fire drills took place between 12:30 a.m. and 2:00 a.m. for four of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant</p>	K 0050	<p>K050</p> <p>The deficient practice could affect all residents in the facility as well as staff and visitors.</p> <p>To correct the deficient practice, the inservice director and maintenance staff were re-educated on conducting fire drills at unexpected times.</p> <p>To ensure this deficient practice does not occur again, maintenance staff or designee will complete "Life Safety Review" monthly to ensure compliance. (Attachment A).</p>	02/07/2016

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K 0052 SS=C Bldg. 01	<p>acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 smoke detector systems 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 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</p>	K 0052	<p>K052</p> <p>Smoke Detector Sensitivity testing on the fire alarm was done on 10/8/15 by facility vendor. Due to circumstances out of facility's control the report was not provided to facility.</p> <p>Results of the Sensitivity Test performed on 10/8/15 are available upon request.</p> <p>A letter was provided from facility vendor explaining situation (Attachment C).</p>	02/07/2016

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	<p>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 range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 12:33 p.m., the most recent documentation of a smoke detector</p>			

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K 0056 SS=E Bldg. 01	<p>sensitivity test was completed by Communications Company dated 09/07/13. Based on an interview with Maintenance Supervisor and Maintenance Assistant at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</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</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinklers in the Room 16, Room 15, and Therapy Bathroom was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray</p>	K 0056	<p>K056</p> <p>This deficient practice has the potential to affect staff and 3 patients that were present at the time.</p> <p>To correct this deficient practice, all obstructions to the sprinkler heads were fixed immediately by facility maintenance staff.</p> <p>To ensure this deficient practice</p>	02/07/2016

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	<p>patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff and 3 residents in Therapy.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 between 1:41 p.m. and 2:20 p.m., the spray pattern for the following sprinkler heads was obstructed:</p> <p>a. 1 of 1 sprinkler head in Room 16 a fan/light combo was obstructed 8 inches away and 5 inches below the sprinkler head.</p> <p>b. 1 of 1 sprinkler head in Room 15 a fan/light combo was obstructed 8 inches away and 5 inches below the sprinkler head. Also, the bathroom sprinkler head deflector was bent.</p> <p>c. 1 of 1 sprinkler head in the Therapy bathroom a boxed light was 2 inches away and 1/4 inch below the sprinkler head.</p> <p>Based on interview at the time of observation, the Administrator acknowledged the abovementioned conditions and provided the</p>		<p>does not occur again, facility approved vendor and maintenance staff/designee will perform an audit to ensure all sprinkler heads are free from obstruction by 2/7/16. Results will be documented.</p>				

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K 0062 SS=F Bldg. 01	<p>measurements.</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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p>	K 0062	<p>K062</p> <p>1.Sprinkler Inspection 1.The deficient practice could affect alloccupants in the facility including staff, visitors, and residents. 2.Please see attached documentation from Safe Careshowing inspection done on 11/23/15. (Attachment D) 2.Sprinkler Head in North Skilled Spa Room 1.This deficient practice could affect up to 1resident. 2.To correct this deficient practice maintenancestaff fixed the sprinkler head in North skilled spa immediately. 3.To ensure this deficient practice does not occuragain, facility maintenance staff or designee will inspect all sprinkler headsto ensure compliance. Results will bedocumented. 4.This will be completed by 2/7/16. 3.Sprinkler Pipes</p>	02/07/2016

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	<p>Findings include:</p> <p>Based on review of sprinkler system documentation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 12:32 p.m., no documentation was available for review for an internal inspection of the sprinkler system pipes. Based on interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 3 sprinkler heads in the North Skilled Spa Room. LSC 33.2.3.5.2 refers to LSC 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 and up to 1 resident.</p> <p>Findings include:</p>				<p>1.This deficient practice has the potential tostaff.</p> <p>2.To correct this deficient practice, maintenancestaff or designee will remove the wiring from the three areas mentioned by2/7/16.</p> <p>3.To ensure this does not occur again, facilityvendor will conduct audit to ensure compliance. Results will be documented.</p> <p>4.All deficiencies will be corrected by 2/7/16.</p>		

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	<p>Based on observation with Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 1:50 p.m., a North Skilled Spa Room sprinkler head deflector was bent. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant 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 3 Sprinkler Attic Pipes above the Mop Room, North Skilled Wing, and Terrace 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 non-system components. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 between 10:58 a.m. to 11:29 p.m., one sprinkler pipe in each of the Mop Room, North Skilled Wing, and Terrace Wing attics had wiring attached and were being</p>			

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K 0064 SS=E Bldg. 01	<p>used as support for the wiring along the bath of the sprinkler pipe. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 12 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff and 22 residents.</p> <p>Findings include: Based on observation with the</p>	K 0064	<p>K064</p> <p>1.Orchard Wing Fire Extinguisher 1.The deficient practice could affect staff and 22patients. 2.To correct this deficient practice fireextinguisher was moved to appropriate height immediately by facilitymaintenance staff. 3.To ensure this deficient practice does not occuragain all extinguishers will be checked for appropriate height by maintenancestaff by 2/7/16.</p> <p>2.Laundry room Fire Extinguisher 1.The deficient practice could affect staff. 2.To correct this deficient practice, the fireextinguisher was removed from laundry room immediately by maintenance</p>	02/07/2016

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	<p>Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 12:57 p.m., the Orchard Wing fire extinguisher measured 64 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 Laundry fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 at 10:48 p.m., a Laundry fire extinguisher maintenance tag indicated the last six year test was completed 04/08. The last annual test was 04/11. The last monthly check was 11/25/11. Based on interview at the time of observation, the</p>		<p>staff. This extinguisher was not in service and was not needed in this area.</p> <p>To ensure this deficient practice does not occur again, maintenance staff or designee will complete the Monthly Inspection of Fire Extinguishers (Attachment E).</p>				

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K 0066 SS=E Bldg. 01	<p>Maintenance Supervisor and Maintenance Assistant 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 not permitted for staff and residents was maintained. This deficient practice could staff and 14 residents.</p> <p>Findings include:</p>	K 0066	<p>This deficiency has the potential to affect all staff and 14 patients. This campus is a smoke free campus. To correct this deficiency, cigarette butts were disposed of appropriately by maintenance staff.</p> <p>To ensure all this does not occur again, staff will be re-educated on</p>	02/07/2016

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K 0067 SS=F Bldg. 01	<p>Based on observations with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 2:16 p.m., there were at least 6 cigarette butts on the ground and 6 cigarette butts in the trash. No approved metal container with a self-closing cover was provided. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 67 of 82 rooms were not using the corridor as a portion of a return air system/plenum for the heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving</p>	K 0067	<p>non-smoking policy on campus. Outdoor trash receptacles were removed from all entrances. This will be done by 2/7/16.</p> <p>K067 The facility has applied for an annual waiver for this deficiency.</p>	02/07/2016			

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K 0072 SS=E Bldg. 01	<p>adjoining areas. This deficient practice could affect 90 residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 between 10:34 a.m. and 12:40 p.m., the resident rooms located on ICF II, ICF III, North SNF, and the Terrace wing and the residential hall were using the egress corridors as a return air system. Based on interview at the time of record review, the Maintenance Supervisor confirmed the return air was exhausted in the corridor for the adjoining rooms and a waiver had be requested last year.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full</p>	K 0072	<p>K072</p> <p>1.Terrace Exit Door 1.This deficiency has the potential to affectstaff and up to 18 patients.</p>	02/07/2016			

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	<p>instant use in the case of fire or other emergency for 1 of 4 exterior discharges. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include: Based on an observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 3:16 p.m., the Terrace exit discharge was interrupted by a large pile of snow/ice. Based on an interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant confirmed the snow/ice pile was from a snow plow and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 1 of 11 egress paths. This deficient practice could affect staff and up to 14 residents.</p> <p>Findings include: Based on an observation with the Maintenance Supervisor and Maintenance Assistant on 01/07/16 at 2:03 p.m., a large scale was in the corridor to the Skilled North exterior exit. The scale and a piece of furniture caused the corridor's clear width to be 42.5</p>		<p>2.To correct his deficient practice maintenancestaff called plow contractor to remove snow/ice from area immediately.</p> <p>3.To ensure this deficiency does not occur again,facility plow vendor was re-educated on importance of keeping all areas ofegress free of obstruction via letter dated 1/25/16 (Attachment F)</p> <p>4.Life Safety Review will be done by MaintenanceStaff or designee weekly for four weeks and monthly there after to ensurecompliance (Attachment A).</p> <p>2.Skilled North Exit</p> <p>1.This deficient practice has the potential toaffect staff and up to 14 patients.</p> <p>2.To correct this deficient practice, the scale andpiece of furniture was moved to a new location on 1/7/16.</p> <p>3.Life Safety Review will be done by MaintenanceStaff or designee weekly for four weeks and monthly there after to ensurecompliance (Attachment A).</p>	

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 635 OAKHILL AVE PLYMOUTH, IN 46563			
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K 0074 SS=D Bldg. 01	<p>inches. Based on an interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 window curtains in room 26 was flame retardant. This deficient practice could affect staff and 2 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and</p>	K 0074	<p>K074 This deficient practice has the potential to affect staffand 2 patients. To correct this deficient practice window curtains wereremoved and family notified by facility of need of documentation. To ensure this deficiency does not occur again, all othercurtains will be checked for compliance by facility staff by 2/7/16.</p>	02/07/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155102	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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K 0147 SS=E Bldg. 01	<p>Maintenance Assistant on 01/08/16 10:18 a.m., the window curtains in resident room 26 in the ICF hall lacked attached documentation that they were inherently flame retardant. Based on interview at the time of observation, the Maintenance Supervisor and Maintenance Assistant confirmed there was no documentation regarding flame retardancy for the window curtains and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were used as per manufacturer's recommendation. This deficient practice affects staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Assistant on 01/08/16 at 10:26 a.m. then again at 10:37 a.m., a surge protector was powering another surge protector powering computer equipment in the Dietary Office. Then</p>	K 0147	<p>K147</p> <p>This deficient practice has the potential to affect staff and up to 16 patients.</p> <p>To correct this deficient practice, Facility approved contractor will install additional outlets to eliminate the need for surge protectors in those two areas identified.</p> <p>To ensure deficient practice does not occur again, maintenance personnel will monitor use of surge protectors on Life Safety Review monthly (Attachment A).</p> <p>All deficiencies will be corrected by 2/7/16</p>	02/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155102	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/08/2016
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	again, a surge protector was powering another surge protector in the Telephone Room. Based on interview at the time of each observation, the Maintenance Supervisor and Maintenance Assistant acknowledged each aforementioned condition. 3.1-19(b)				