

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155006	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2014
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 N ALBER ST WABASH, IN 46992
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K010000	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/20/14</p> <p>Facility Number: 000006 Provider Number: 155006 AIM Number: 100290220</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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a</p>	K010000	Please accept this plan of correction as credible allegation of compliance for the deficiencies cited during our annual Life Safety Code survey conducted on November 20, 2014 at Miller's Merry Manor Wabash East Facility.	

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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K010025 SS=E	<p>capacity of 84 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered with the exception of a detached garage used for storage of maintenance equipment and parts, a detached shed used for storage of repair parts and another detached shed used for the storage of activity supplies.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/05/14.</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 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 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,</p>						

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	<p>19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 31 residents.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Supervisor on 11/20/14 at 12:57 p.m., in the attic at the 100 hall smoke barrier wall there were two unsealed penetrations around data lines. Based on an interview at the time of observation, the Maintenance Supervisor confirmed each unsealed penetration measured one inch.</p> <p>3.1-19(b)</p>	K010025	<p>It is the policy of Miller's Merry Manor to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating. All residents have the potential to be affected by this deficient practice. The space around the pipe running through the fire barrier was filled with fire barrier sealant on 11/21/14. No residents residing in the facility experienced negative consequences as a result of this finding. To prevent reoccurrence attachment "A" will be filled out monthly by the maintenance supervisor or designee for the first three months and quarterly thereafter. All changes will be completed by 12/20/14.</p>	12/20/2014			

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half 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 was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 11/20/14 at 12:25 p.m., there were six unsealed penetrations in the kitchen ceiling above the hood suppression system near the kitchen hood. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the unsealed penetration measured in size from three fourths inch to one sixteenth inch.</p> <p>3.1-19(b)</p>						

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K010062 SS=D	<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>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the closet of resident room 201 was maintained. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 11/20/14 at 11:22 a.m., only the deflector of the closet sprinkler head in resident room 201 could be seen through a hole in the ceiling drywall. Based on an interview at the time of observation, the Maintenance Supervisor acknowledged the closet sprinkler head would be obstructed by the ceiling drywall.</p> <p>3.1-19(b)</p>	K010062	<p>It is the policy of Miller's Merry Manor to ensure that automatic sprinkler systems are continuously maintained in reliable operating conditions and inspected and tested periodically. All residents have the potential to be affected by this deficient practice. To correct his deficiency the sprinkler escutcheon was replaced on 11/21/14. No residents residing in the facility experienced negative consequences as a result of this finding. To prevent reoccurrence attachment "A" will be used by the maintenance supervisor or designee monthly for three months and quarterly thereafter. All changes will be completed by 12/20/14.</p>	12/20/2014			
K010074 SS=D	<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</p>						

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	<p>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 the closet curtains in 1 of 47 resident rooms were flame retardant. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 11/20/14 at 11:20 a.m., the curtains hanging at the closet of resident room 201 lacked attached documentation confirming they were inherently flame retardant. Based on interview at the time of observation, the Maintenance Supervisor confirmed the curtains were hung at the closet for the safety of the resident and had not been treated with a flame retardant chemical.</p> <p>3.1-19(b)</p>	K010074	<p>It is the policy of Miller's Merry Manor to ensure that all draperies, curtains, and other loosely hanging fabrics are flame retardant. All residents have the potential to be affected by this deficient practice. To correct this deficiency curtains were treated with "Flame No More" per manufactures specifications on 12/9/14. No residents residing in the facility experienced negative consequences as a result of this finding. To prevent reoccurrence attachment "A" will be used by the maintenance supervisor or designee monthly for three months and quarterly thereafter. All changes will be completed by 12/20/14.</p>	12/20/2014			

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview, the facility failed to ensure 1 of 1 new additions meet the design requirements. NFPA 101 Section 19.1.1.3 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could effect any occupant evacuated through the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 11/20/14 during a tour of the facility from 11:15 a.m. to 1:05 p.m., the newly constructed main entrance/conference room/therapy gym area was being used as the main entrance into the facility. Based on record review with the Administrator at 1:10 p.m., the only documentation provided was Certificate of Occupancy and Compliance from the City of Wabash. Based on interview at the time of record review, the Administrator was</p>	K010130	<p>It is the policy of Miller's Merry Manor to ensure new additions meet the design requirements. All residents have the potential to be affected by this deficient practice. To correct this deficiency all paperwork requested by the ISDH has been submitted. No residents residing in the facility experienced negative consequences as a result of this finding. We have been working with Brett Overmyer and the ISDH. All paperwork is on file.</p>	12/20/2014
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K010143 SS=E	<p>unable to confirm any construction plans had been submitted for review to the Indiana State Department of Health Health Facility Plan Review Section.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the</p>	K010143	<p>It is the policy of Miller's Merry Manor to ensure that oxygen is stored in accordance with ISDH regulations. All residents have the potential to be affected by this deficient practice. To correct this deficiency the electrical switch was removed and a blank cover was installed over the junction box on 11/25/14 per surveyor recommendation. No residents residing in the facility experienced</p>	12/20/2014

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K019999	<p>floor to avoid physical damage. This deficient practice could affect 31 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 11/20/14 at 12:00 p.m., the oxygen transferring room with at least two large liquid oxygen cylinders had one electrical switch on the wall fifty three inches above the floor. Based on an interview at the time of observation, the Maintenance Supervisor stated the room was recently enlarged and acknowledged the switch was located fifty three inches from the floor.</p> <p>3.1-19(b)</p> <p>State Findings:</p> <p>3.1-2 LICENSES The applicant shall prior to the start of construction, submit detailed architectural and operational plans to the division for consideration and approval. The plans shall state the licensure classification sought. Plans for projects</p>	K019999	<p>negative consequences as a result of this finding. To prevent reoccurrence attachment "A" will be used by the maintenance supervisor or designee monthly for three months and quarterly thereafter. All changes will be completed by 12/20/14.</p> <p>It is the policy of Miller's Merry Manor to ensure new additions meet the design requirements. All residents have the potential to be affected by this deficient practice. To correct this deficiency all paperwork requested by the ISDH has been submitted. No residents residing in the facility experienced negative consequences as a result of</p>	12/20/2014	

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	<p>involving less than thirty thousand (30,000) cubic feet require suitable detailed plans and sketches. Plans for projects involving more than thirty thousand (30,000) cubic feet require certification by an architect or an engineer registered in Indiana. A plan of operation, in sufficient detail to facilitate the review of functional areas, that is, nursing unit, laundry, and kitchen, shall accompany the submitted plan.</p> <p>Additionally, (r) The facility must operate and provide services in compliance with: (1) all applicable federal, state, and local laws, regulations, and codes.</p> <p>This State Rule was not met as evidenced by: Based on observation and interview, the Facility Management failed to comply with 16.2-3-2(c)(3) which requires suitable detailed plans and sketches and 16.2-3.1-13(r)(1) operate in compliance with all applicable federal, state and local laws for 1 of 1 main entrance/conference room/therapy gym area under reconstruction be submitted for review. This deficient practice could affect residents evacuated through the newly constructed main entrance.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>this finding. We have been working with Brett Overmyer and the ISDH. All paperwork is on file.</p>				

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	<p>Maintenance Supervisor on 11/20/14 during the tour between 11:15 a.m. and 1:05 p.m., the main entrance/conference room/therapy gym was newly constructed and being used by residents and visitors and no rudimentary plans had been submitted for review. Based on record review with the Administrator at 1:10 p.m., the only documentation of design or construction approval provided was a Certificate of Occupancy and Compliance from the City of Wabash. Based on an interview at the time of record review, the Administrator was unable to confirm any construction plans had been submitted for review to the Indiana State Department of Health Health Facility Plan Review Section. Based on a telephone interview with Maintenance Man #1 on 12/05/14 at 8:46 a.m., the new addition measures 31,669 cubic feet.</p> <p>410 IAC 16.2-3-2(c)(3) 410 16.2-3.1-13(r)(1)</p>				