

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/18/2011
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN46173
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K0000	<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: 10/18/11</p> <p>Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930</p> <p>Surveyor: Mark Bugni, 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The healthcare portion of the facility has a capacity of 98 and had a census of 76 at</p>	K0000		

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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K0027 SS=E	<p>the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/19/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 16 residents who reside on the Center Hall.</p> <p>Findings include:</p>	K0027	Residents didn't experience a negative outcome from this deficient practice. We tightened affected hinges and sanded edges of doors. This allowed for proper closing of doors leaving the desired gap concerning state code. The addressed item was fixed on 10/24/11. To ensure no other residents were affected by the standard identified by the surveyor we checked all other smoke barrier doors to establish proper compliance with this life safety code. Compliance of this code will be ensured during preventive maintenance checks identifying possible issues. A work order will be	11/17/2011

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K0048 SS=F	<p>Based on observation on 10/18/11 at 12:50 p.m. with the maintenance supervisor, the Center Hall set of smoke barrier doors had a one inch gap where the pair of doors met. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to include the use of two kitchen portable fire extinguishers in the written plan for the protection of 76 of 76 residents in the event of an emergency. 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"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects all residents in the facility.</p>	K0048	<p>established if an issue is found and the item will be resolved. This safety code will be revisited monthly as part of the quality assurance meeting. This will occur for the next three months and as needed thereafter. All changes will be completed by 11/17/2011.</p> <p>Residents didn't experience a negative outcome from this deficient practice. We have added clarification in the disaster manual concerning use of ABC and K class fire extinguishers secondary to the overhead hood extinguishing system on 10/31/11. We have ordered new signs to install over the two fire extinguishers that will state the following: This is a secondary extinguisher ONLY use primary system first. Dietary staff will hold an in-service concerning this code and plan of correction on 11/7/2011. Maintenance staff has inspected all other fire extinguishers to ensure they are identified properly and no other residents can potentially be affected concerning this code. We will identify issues concerning this code by preventive</p>	11/17/2011

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	<p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan labeled Disaster Plan on 10/18/11 at 9:40 a.m. with the maintenance supervisor, the Disaster Plan did not address the use of the ABC class fire extinguisher and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, the K class fire extinguisher lacked a placard indicating it's use is secondary to the overhead hood extinguishing system. Based on an interview with the maintenance supervisor on 10/18/11 at 10:45 a.m., it was not known if the kitchen staff are trained to activate the overhead hood extinguishing system to suppress a fire before using the ABC class fire extinguisher or the K class fire extinguisher. The lack of identification and use of the ABC class fire extinguisher and K class fire extinguisher in the Disaster Plan was confirmed by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p>		<p>maintenance checks, which will place environmental staff in all areas of building. If items are identified during these checks we will reference this code to make sure we are in compliance. This safety code will be revisited monthly as part of the quality assurance meeting. This will occur for the next three months and as needed thereafter. All changes will be completed by 11/17/20011</p>		

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K0064 SS=E	<p>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 maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 10/18/11 at 10:45 a.m. with the maintenance supervisor, the kitchen K class fire extinguisher, located on the north wall near the cooking surface, lacked a placard indicating the kitchen fire protection system was to be activated prior to using the K class fire extinguisher. Based on interview on 10/18/11 at 10:55 a.m. with the maintenance supervisor, it was acknowledged the K class portable fire extinguisher lacked a placard.</p> <p>3.1-19(b)</p>	K0064	Residents didn't experience a negative outcome from this deficient practice. We have ordered a new sign to install over the K class fire extinguisher that will state the following: This is a secondary extinguisher ONLY use primary system first. To ensure no other residents were affected by the standard identified maintenance has ensured all other fire extinguishers are properly identified. Dietary staff will hold an in-service on this code and plan of correction on 11/7/2011. The lack of placards will be identified by preventive maintenance checks, which will place environmental staff in all areas of building. This safety code will be revisited monthly as part of the quality assurance meeting. This will occur for the next three months and as needed thereafter. All changes will be completed by 11/17/11.	11/17/2011	