

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 08/28/2013
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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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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: 08/28/13</p> <p>Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</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</p>	K010000	<p>K017 The deficient practice could affect any staff, visitor, or resident using the Occupational and Physical Therapy rooms for treatment. To correct the deficient practice an automatic, positive latches will be placed on the two sets of doors. To ensure the deficient practice does not recur all doors in the facility were assessed for the need for automatic positive latches. All other doors found to be in compliance. The corrective actions will be performed by an outside contractor and monitored by the Maintenance Supervisor and/or designee for completion. Changes will be completed by 9/27/2013</p>	
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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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	<p>completed in 1974 with the Orchard wing and Main hall added in 1985. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors with battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 135 beds with 131 certified beds and 4 residential beds. The facility had a census of 82 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached sheds for facility storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 areas were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet an Exception. LSC 19-3.6.1, Exception # 1 - Smoke compartments protected throughout by an approved, supervised, automatic sprinkler system in accordance with 19.3.6.1 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the space opens in the same smoke compartment are protected by an electrically supervised automatic smoke</p>	K010017	K017 The deficient practice could affect any staff, visitor, or resident using the Occupational and Physical Therapy rooms for treatment. To correct the deficient practice an automatic, positive latches will be placed on the two sets of doors. To ensure the deficient practice does not recur all doors in the facility were assessed for the need for automatic positive latches. All other doors found to be in compliance. The corrective actions will be performed by an outside contractor and monitored by the Maintenance Supervisor and/or designee for completion. Changes will be completed by 9/27/2013	09/27/2013			

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	<p>detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the entire space is arranged and located to allow direct supervision by facility staff from a nursing station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any number of residents using the Occupational and Physical Therapy rooms and staff or visitors in the vicinity of those two rooms.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the Occupational and Physical Therapy rooms had glass paned double doors with ball latches at the top of the doors and not automatic, positive latching. The two rooms were also protected by an electrically supervised automatic smoke detection system, however, the Exception # 1 of the LSC Section 19-3.6.1 was not met because the spaces were being used for therapy which is a treatment. Based on interview at the time of observation, the Maintenance</p>				

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	Supervisor acknowledged the therapy rooms were recently reconfigured and the doors were added or changed. 3.1-19(b)			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>Based on observation and interview, the facility failed to ensure 1 of 12 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect 10 of 82 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the Skilled North wing nourishment storage room exceeded 50 square feet and the door was not provided with a door closer The room was used for the storage of combustible boxes and paper supplies. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the door to this room lacked a door closer and would need to be manually pulled</p>	K010029	K029 The deficient practice could affect 10 of 82 residents, as well as staff and visitors. To correct the deficient practice an automatic door closer was installed on the affected door on 8/28/13. To ensure the deficient practice does not recur, all other doors in the facility were assessed for the need for automatic positive latches. All other doors found to be in compliance. The corrective actions were corrected immediately by in-house maintenance supervisor. Door will be monitored by Maintenance Supervisor and/or designee on a monthly basis using QA tool labeled Monthly Preventative Maintenance Report – revised (Attachment # 5)	09/27/2013			

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	shut to latch the door. 3.1-19(b)			

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K010038 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 5 of 15 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects at least 50 of 82 residents and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, exit doors identified as #2, #3, #5, #6 and #15 were provided with magnetic locks and could be opened by entering a four digit code which was</p>	K010038	K038 The deficient practice could affect 50 of 82 resident and visitors. To correct the deficient practice instructions were posted at each door found not to be in compliance. The corrective actions were corrected immediately by Director of Support Services. All doors will be monitored by the Maintenance Supervisor and/or designee on a monthly basis using QA tool labeled Monthly Preventative Maintenance Report-revised (Attachment #5)	09/27/2013			

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	<p>not posted. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the code was not posted on these doors and indicated the Terrace wing is an Alzheimer's unit with residents with a clinical diagnosis requiring specialized security measures. Any resident without a clinical diagnosis requiring specialized security measures or any visitor outside of the Terrace wing would have to ask a staff member for exit access if they did not know the code.</p> <p>3.1-19(b)</p>			

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K010056 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect any resident or staff using the Skilled south spa.</p> <p>Findings include:</p>	K010056	K056 The deficient practice could affect any resident or staff using this area. The area is not currently being used by any staff or resident. To correct the deficient practice an outside vendor removed the extra sprinkler head located in the Spa. To ensure the deficient practice does not recur all other areas were checked to ensure compliance with LSC Standard. The corrections actions were corrected on 9/ 5/13 by an outside vendor and verified by Maintenance Supervisor.	09/27/2013			

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	<p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the Skilled south spa had two sprinklers three feet apart. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the spa had been recently reconfigured with a wall taken out between the sprinklers.</p> <p>3.1-19(b)</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 1 of 30 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice would have a minimal affect on any resident, staff and/or visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the annual maintenance tag attached to the portable fire extinguisher located on a window shelf in the housekeeping office/storage room indicated the last annual maintenance procedure for the extinguisher was performed in April, 2011. Based on</p>	K010064	<p>K064 The deficient practice had potential for minimal affect on any resident, staff and/or visitor. All fire extinguishers "in use" are checked on a monthly basis by the Maintenance Supervisor and /or designee. To correct the deficient practice the Maintenance Supervisor removed the out of service extinguisher from the Housekeeping Storage room. To ensure the deficient practice does not recur all other extinguishers were checked for compliance. No other extinguishers were found to be out of service. The correction actions were corrected on 9/28/13 by Maintenance Supervisor. "In use" fire extinguishers are checked on a monthly basis by the Maintenance Supervisor and/or designee using QA tool "Fire Extinguisher Check Log" (Attachment #6)</p>	09/27/2013			

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	<p>interview at the time of observation, the Maintenance Supervisor acknowledged the portable fire extinguisher was no longer in service by the facility and should not have been located in the office/storage room.</p> <p>3.1-19(b)</p>			

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K010067 SS=E	<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 observations 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 adjoining areas. This deficient practice could affect at least 50 residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the resident rooms located on ICF 2, ICF 3, South SNF, North SNF, and the Terrace wing were using the egress corridors as a return air system. Based on interview at the time of observations with the Maintenance Supervisor, it was confirmed the return air</p>	K010067	K067Facility has requested an annual waiver for this deficiency.	09/27/2013			

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	was exhausted into the corridor for the aforementioned adjoining rooms. 3.1-19(b)			

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K010074 SS=B	<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 sprinklers in areas where cubicle curtains are installed were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems in 1 of 80 rooms. This deficient practice could affect any resident using the Orchard wing tub room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 11:35 a.m. to 2:15 p.m. on 08/28/13, the Orchard wing tub room had one sprinkler with a privacy curtain that lacked a 1/2 inch diagonal</p>	K010074	K074 The deficient practice could affect any resident using the Orchard wing Tub room. The tub is not used by any resident or staff member. To correct the deficient practice the Maintenance Supervisor removed the privacy curtain that was not in compliance and replaced it with a curtain that was in compliance. To ensure the deficient practice all other curtains were checked and found to be in compliance. The corrections actions were corrected on 9/28/13 by Maintenance Supervisor.	09/27/2013			

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 08/28/2013
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	<p>mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the privacy curtain was a solid curtain that extended all the way to the ceiling and would not allow water from the sprinkler to penetrate.</p> <p>3.1-19(b)</p>			