

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 04/20/2015
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NAME OF PROVIDER OR SUPPLIER MILLERS MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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K 000 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: 04/20/15</p> <p>Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930</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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 98 and had a census of 85 at</p>	K 000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted on April 20, 2015 at Miller's Merry Manor. Please find the enclosed Plan of Correction that is respectfully submitted as remedies to the deficiencies that were found during our survey. I would like to request your consideration in granting paper compliance for the entire plan of correction due to the low scope and severity of the tags.</p>	

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 025 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage buildings which were not sprinkled.</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, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 3 of 139 room walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable 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</p>	K 025	<p>All areas documented were corrected and smoke barrier material and drywall was applied to meet the standard.</p> <p>All residents have the potential to be effected by this deficient practice. An audit was done through the entire building to ensure ceilings were constructed with least a one half hour fire resistance rating and that any area where the smoke barrier had been penetrated had been appropriately filled with a material capable of maintaining the</p>	05/20/2015

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	<p>deficient practice affects 48 residents who reside on the Northeast Hall, 36 residents who reside on the Southwest Hall, and 68 residents who use the main dining room which is located adjacent to the receptionist office.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and assistant maintenance supervisor during a tour of the facility on 04/21/15 from 10:00 a.m. to 1:20 p.m., the following locations had ceiling and wall penetrations not firestopped or had missing drywall;</p> <ol style="list-style-type: none"> 1. Resident room 24 closet ceiling had a one foot by one foot area of drywall missing. 2. Resident room 26 closet ceiling had a one half inch gap around a cable television penetration not firestopped. 3. Resident room 22 closet south wall had a one half inch gap around a sprinkler pipe penetration not firestopped. 4. Resident room 4 closet south wall had a one half inch gap around a cable television penetration not firestopped. 5. Resident room 6 closet east wall had a one inch gap around a sprinkler pipe penetration not firestopped. 6. Resident room 52 closet ceiling had a one inch gap around a sprinkler pipe 		<p>smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. To ensure the deficient practice does not recur the Maintenance Director and Assistant Maintenance Director were educated that an inspection must be completed following any work completed by a vendor to ensure that any smoke barriers that are penetrated will be appropriately filled with a material capable of maintaining the smoke resistance of the smoke barrier or by an approved device designed for the specific purpose.</p> <p>Maintenance Director and assistant were educated that "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."</p>	

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K 027 SS=E Bldg. 01	<p>penetration not firestopped.</p> <p>7. The West Wing clean utility room ceiling had two, one inch gaps around electrical conduit penetrations not firestopped.</p> <p>8. The therapy hydrocollator room ceiling had a one inch gap around a cable bundle not firestopped.</p> <p>9. The front receptionist closet ceiling had a one half inch gap around a square metal furnace plenum not firestopped. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the assistant maintenance supervisor at the exit conference on 04/20/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the</p>	K 027	<p>Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A)</p> <p>This deficient practice could affect 16 residents who reside on the West</p>	05/20/2015			

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K 029 SS=E Bldg. 01	<p>movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 16 residents who reside on the West Wing near the West Wing Center Hall.</p> <p>Findings include:</p> <p>Based on observation on 04/20/15 at 12:20 p.m. with the maintenance supervisor and assistant maintenance supervisor, the West Wing Center Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the assistant maintenance supervisor at the exit conference on 04/20/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with %</p>		<p>Wing near the West Wing Center Hall. Corrections have been made to eliminate those residents from being affected. Maintenance Director and Assistant Maintenance Director fixed the door stops on the smoke barrier doors in order to be in compliance with LSC, Section 8.3.4. which requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke.</p> <p>Maintenance Director and Assistant Maintenance Director educated on the above requirement.</p> <p>Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A)</p>		

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	<p>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 the corridor door to 1 of 12 hazardous areas, such as a combustible storage room over 50 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 12 residents who use the therapy room.</p> <p>Findings include:</p> <p>Based on observation on 04/20/15 at 1:00 p.m. with the maintenance supervisor and assistant maintenance supervisor, the therapy supply room, which measured eighty four square feet and stored fourteen shelves of combustible cardboard boxes of plastic pads and adult briefs, lacked a self closing device on the door. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of</p>	K 029	<p>Maintenance Director to install automatic closing latch to correct this deficient practice immediately. This deficient practice could affect 12 residents who use the therapy room but the intervention put into place protects these residents from the deficient practice.</p> <p>Maintenance Supervisor and Assistant Maintenance Supervisor educated that when contents of room are changed to include hazardous material, such as a combustible storage room over 50 square feet, we are to provide it with a self closing device which could cause the door to automatically close and latch into the door frame.</p> <p>Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety</p>	05/20/2015

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K 062 SS=F Bldg. 01	<p>observation and acknowledged by the assistant maintenance supervisor at the exit conference on 04/20/15 at 1:30 p.m.</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 observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the maintenance supervisor and assistant maintenance supervisor on</p>	K 062	<p>Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A)</p> <p>1. Fire hydrant inspection was completed on April 25, 2015. The fire hydrants in the vicinity have been checked and are in good working condition. (Attachment B) Maintenance supervisor was educated that the fire hydrant is to be inspected annually and after each operation. Administrator and/or Regional Maintenance Supervisor will audit using the QA Tool titled, "Life Safety Code" weekly for one month, monthly for three months, and quarterly thereafter. (Attachment A) All residents have potential to be affected by this deficient practice. The corrections that have been made eliminate all residents from being affected going forward.</p> <p>2. Sprinklers identified were</p>	05/20/2015

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	<p>04/20/15 at 1:00 p.m., the East Wing had one fire hydrant located outside the exit door. Based on an interview with the assistant maintenance supervisor on 04/20/15 at 1:10 p.m., there is no annual inspection record for the fire hydrant. The lack of an annual inspection for the one fire hydrant located outside the East Wing was verified by the assistant maintenance supervisor at the time of interview and acknowledged by the assistant maintenance supervisor at the exit conference on 04/20/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 2 of over 300 sprinklers in the facility covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested 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 4 residents who reside in resident rooms 25 and 26.</p> <p>Findings include:</p>		<p>replaced with new sprinklers. All residents have potential to be affected by this deficient practice. Interventions that have been made eliminate all residents from being affected going forward.</p> <p>All sprinklers in the facility were check and no other sprinklers found covered in corrosion and paint.</p> <p>Maintenance director or designee will conduct audit titled "Sprinkler System" (Attachment C) weekly for one month and monthly thereafter to maintenance system TELS to ensure sprinklers are not covered in corrosion and paint.</p>	

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	<p>Based on observations on 04/20/15 during a tour of the facility from 10:00 a.m. to 1:30 p.m. with the maintenance supervisor and assistant maintenance supervisor, resident rooms 25 and 26 each had a sprinkler covered in white paint. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the assistant maintenance supervisor at the exit conference on 04/20/15 at 1:30 p.m.</p> <p>3.1-19(b)</p>				