

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155627	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 ALBER ST WABASH, IN 46992
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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: 02/01/12</p> <p>Facility Number: 000578 Provider Number: 155627 AIM Number: 100267810</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 III (200) construction and was fully</p>	K0000		
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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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 44 and had a census of 30 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/07/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0021 SS=E	<p>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 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 2 sets of smoke barrier doors were held open only by a device which would allow them to close automatically upon activation of the fire alarm system. This deficient practice could affect two of three smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 12:17 p.m., the smoke barrier doors on the West hall were held in the open position by a medication cart. This was confirmed by the Maintenance</p>	K0021	<p>It is the policy of Miller's Merry Manor West that any door in the facility 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 : a) the required manual fire alarm system; b)local smoke detector's designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed.1. The medication cart preventing the smoke barrier doors on the west hall from closing was moved to another location.2. All residents had the potential to be affected by this deficient practice. There will be no medication carts preventing the smoke barrier doors on any hall from closing.3. All staff will be re-in-serviced on not placing</p>	03/02/2012	

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	Supervisor at the time of observation. 3.1-19(b)		medication carts or any objects in front of the smoke barrier doors. 4. The Director of nursing of designee will check to make sure the medication cart is not in front of any smoke barrier doors using the QA tool titled "Mediation Cart placement.(Attachment A) daily for one month then weekly thereafter. Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012.		

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K0025 SS=D	<p>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 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 could affect any resident near the West hall furnace room.</p> <p>Findings include:</p> <p>Based on an observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 11:50 a.m., there is a twelve by fourteen inch ceiling vent open to the attic in the West hall furnace room. Measurements were provided by the Corporate Services Representative.</p>	K0025	<p>It is the policy of Miller's Merry Manor West that the facility's smoke barriers are constructed to provide at least 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 barrier in fully ducted heating, ventilating, and air conditioning systems.1. The opening in the ceiling to the attic in the West hall furnace room will be covered by a vent.2. All resident have the potential to be affected by this deficient practice. All openings in the facility will be checked and will be covered by a vent, if necessary.3. Staff will be re-in-serviced that there should be no openings in the ceiling, walls, and floors in the facility. If an opening is found a maintenance work order should</p>	03/02/2012			

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	3.1-19(b)		be filled out immediately.4. Maintenance director or designee will check for openings in the ceiling, walls, and floors daily for one month, then weekly thereafter. (Attachment A) Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012		

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K0029 SS=E	<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 1 of 1 Dutch doors in the kitchen, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect any residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 1:35 p.m., the door between the kitchen and the dining room was in a corridor wall. The door was a Dutch type door with the top section locking into the bottom section. During meal time the top section was opened and used as a serving window. The door was not held in the open position by a device that would</p>	K0029	<p>It is the policy of Miller's Merry Manor that the facility have a one hour fire rated construction (with 3/4 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 area self closing and non rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 1. The door in the kitchen when replaced, will self close upon activation of the fire alarm system, and there will be no gaps between the upper and lower sections of the door. The laundry room door and water heater room door will latch into the frame. 2. All residents have the potential to be affected by this deficient practice. The facility is obtaining quotes and purchasing</p>	03/02/2012			

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	<p>release upon activation of the fire alarm and lacked a self closing device. Additionally, there is a one half inch gap between the upper and lower sections of the door. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 laundry rooms and 1 of 2 water heater rooms would latch into the frame. This deficient practice could affect any resident in the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 from 1:20 p.m. to 1:22 p.m., the corridor door to the water heater room across from the laundry and the door to the laundry washer room did self close, however, it failed to latch into the frame. This was</p>		<p>a new door and replacing the door frame with a self closer in the kitchen that will be connected to the fire alarm and have no gaps between the upper and lower sections. Due to the complexity of buying a new door and replacing the frame the project will be completed within 60 days from March 2, 2012. All doors will be checked to ensure they latch to frame.3. All staff will be inserviced on the new kitchen door being installed, having a self closer, and being connected to the fire alarm. The facility is obtaining quotes and purchasing a new door and replacing the door frame with a self closer in the kitchen that will be connected to the fire alarm and have no gaps between the upper and lower sections. Due to the complexity of buying a new door and replacing the frame the project will be completed within 60 days from March 2, 2012.All doors will be checked to ensure they latch to frame. Maintenance director has installed a door closer on the laundry room door. It now latches into the frame. The water heater room door has been oiled and now latches into the frame. 4. The new door will be monitored by the maintenance director or designee during the fire door monthly inspection. (Attachment C) Maintenance Director or designee will check that the laundry room door and water</p>				

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	confirmed by the Corporate Services Representative at the time of observations. 3.1-19(b)		heater room door latch into the frame using the QA tool "Life Safety Code Review" (Attachment A). This will be done daily for one month, and then weekly thereafter. Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012.		

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K0039 SS=E	<p>Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect any residents evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 1:10 p.m., in the enclosed porch area of the service hall the exit discharge path was only thirty eight inches between the the pop machine and the opposite wall. This was acknowledged by the Corporate Services Representative and the Maintenance Supervisor at the time of observation</p> <p>3.1-19(b)</p>	K0039	<p>It is the policy of Miller's Merry Manor that the width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 1. The enclosed porch area of the service hall will have an exit corridors will have a clear and unobstructed exit width that is at least 4 feet.2. All residents have the potential to be affected by this deficient practice. All exit corridors will have a clear and unobstructed exit width that is at least 4 feet.3. The pop machine that is blocking the discharge path will be removed from the facility leaving a clear and unobstructed exit corridor with width of at least 4 feet. 4. The maintenance director or designee will measure the exit width corridors in the facility for a width of at least 4 feet daily for one month, then weekly thereafter using QA tool titled Life Safety Review (Attachment A). Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012.</p>	03/02/2012			

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K0047 SS=E	<p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 service hall exit signs indicated the access path of exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect any resident evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 1:05 p.m., the exit sign in the service hall lacked a directional arrow indicating the access path of egress to the exit. This was acknowledged by the Corporate Services Representative and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0047	<p>It is the policy of Miller's Merry Manor West that exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 1. The service hall exit sign will indicate the access path of exit. 2. All residents have the potential to be affected by this deficient practice. All exit signs will were checked and no other signs need to indicate the access path of exit. 3. Staff will be re-inserviced on that the service hall exit sign now indicating the access path of exit. 4. The maintenance director or designee will check that all hall exit signs indicate the access path of exit using QA tool "Life Safety Code Review(Attachment A) daily for one month, and then weekly thereafter. Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B) 5. All systemic changes and inservices will be completed by March 2, 2012.</p>	03/02/2012			

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K0066 SS=E	<p>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 areas where smoking was permitted for staff and residents was maintained and the metal container with a self closing cover was used for an ashtray. This deficient practice could affect any resident evacuated through the service hall exit.</p> <p>Findings include:</p> <p>Based on an observation with the</p>	K0066	<p>It is the policy of Miller's Merry Manor that smoking regulations are adopted and include provisions: 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. 2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. 3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. 4)</p>	03/02/2012
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	<p>Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 1:03 p.m., the outside staff and resident designated smoking area was provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts. Three partially smoked unlit cigarettes were observed in the window still of the enclosed porch area behind the space heater. This was acknowledged by the Corporate Services Representative and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 1. There will be no cigarettes observed in the window sill of the enclosed porch area, and the facility has purchase a metal container with a self closing cover. 2. All residents have the potential to be affected by this deficient practice. There will be no cigarettes left in the enclosed porch area and the facility has purchased a metal container with a self closing cover.3. All staff will be re-in-serviced on smoking in only areas designated by the facility and that cigarettes should be disposed of in the metal container with a self closing cover.4. The maintenance director or designee will check the enclosed porch area for cigarettes and that a metal container with a self closing cover is in use using the QA tool titled" Life Safety Code Review". (Attachment A) This will be done daily for one month and then weekly thereafter. Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012.</p>		

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K0070 SS=E	<p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any resident evacuated through the service hall emergency exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 12:57 p.m., a space heater was in use in the enclosed porch area where the vending machines are located. The porch area is in the path of egress from the service hall for resident's emergency evacuation. According to the space heater policy, space heaters will be used only in staff areas. Additionally, the policy failed to include: the heating elements will not exceed</p>	K0070	<p>It is the policy of Miller's Merry Manor West that portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating element does not exceed 212 degrees F.1. The space heater was removed from the path of egress from the service hall for resident's use in an emergency evacuation.2. All residents have the potential to be affected by this deficient practice. All space heaters will be removed from the facility.3. All space heaters in the facility will be removed, and the space heater policy will be updated to reflect the heating elements will not exceed 212 degrees F. All staff will be re-in-serviced that there will be no space heaters in the facility.4. Maintenance director or designee will check facility for portable space heaters daily for one month then weekly thereafter using the QA tool titled "Life Safety Review" Any concerns will be corrected immediately, and will be logged on the QA summary improvement log. (Attachment B)5. All systemic changes and inservices will be completed by March 2, 2012.</p>	03/02/2012			

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	<p>212 degrees F. This was acknowledged by the Corporate Services Representative and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>				

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the load testing for the past 2 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period	K0144	It is the policy of Miller's Merry Manor West that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 1. The generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.2. All residents had the potential to be affected by this deficient practice. The facility will run its diesel powered generator under load for 30 minutes monthly. When the generator load doesn't meet 30 percent of capacity of the name plate rating, or is not operated under operating temperature conditions, the facility will exercise generator annually with supplemental loads.3. The facility is running the diesel generator under load every month for 30 minutes. Since the load is less than 30 percent of the name plate rating, the facility is having supplemental load test performed. H & G will perform a load bank test by March 2, 2012. 4. The maintenance supervisor will monitor that the deficiency does not happen in the future. The corrective action will be monitored by the maintenance director using the QA tool TELS Emergnecy Generator Monthly Load Test (Attachment D) It will be reviewed weekly for 30 days,	03/02/2012			

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	<p>and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the TELS program generator log titled "Monthly Load Test" with the Corporate Services Representative and the Maintenance Supervisor on 02/01/12 at 10:37 a.m., the generator test log showed a monthly load test for the past twelve months for a thirty minute duration but was operated with less than thirty percent of the nameplate rating for the months of December 2011 and January 2012. There was no documentation stating the generator reached operating conditions, or a record of the exhaust gas temperatures. Based on an interview with the Corporate Services Representative at 1:50 p.m. on 02/01/12 during the exit conference, he confirmed the generator did not meet the required thirty percent of the</p>		<p>monthly for 90 days, and quarterly thereafter. 5. All systemic changes and inservices will be completed by March 2, 2012.</p>		

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	nameplate rating, and he thought the generator was required to meet an average of thirty percent annually. 3.1-19(b)				