

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/10/12</p> <p>Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Miller's Merry Manor was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered except for a canopy at the entrance. A later one story addition, consisting of the east wing constructed prior to March 2003, was determined to be Type V (III) also fully sprinklered therefore it was surveyed as one building.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. All resident</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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	<p>rooms were provided with battery operated smoke detectors. The facility has a capacity of 110 and had a census of 75 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage. It was found in compliance with state law regarding smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered except for a canopy attached to the building and extending over the walkway to the main entrance. All areas providing facility services were sprinklered except for two detached storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to have evidence that a canopy was noncombustible or install a sprinkler system in the canopy attached to the building. This deficiency could affect all staff, residents and visitors in the vicinity of the main entrance.</p> <p>Findings include:</p>			K9999	<p>On August 10, 2012, a Quality Assurance walk-thru was conducted. At the time, we were asked to provide documentation that the canopy at the front entrance was noncombustible. This documentation was housed at the corporate office and not available at the facility during the survey. We are now providing documentation showing that when the awning was installed, 7/31/2009, it was constructed with "Sunbrella Firesist fire retardant material" (Attachment 1). This documentation will be kept in the facility Maintenance Office in the Life Safety Code binder so that it can be provided easily during future inspections.</p>		08/10/2012

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	<p>During a tour of the facility with the Maintenance Supervisor on 8/10/12 between 11:45 a.m. and 1:15 p.m., the main entrance/exit doors were found to have a canopy attached to the building which exceeded 4 feet in length and did not include sprinkler coverage. The canopy had a fabric of unknown composition which covered an aluminum frame and was attached to the building above the main entrance and extended outward for 11 feet over the entrance walkway. Interview with the facility Administrator at 1:40 p.m. on 08/10/12 indicated documentation could not be located to show the canopy was constructed from noncombustible material.</p> <p>3.1-19(ff)</p>				