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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155578 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/23/2012 |
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| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E DUNN RD NEW CARLISLE, IN 46552 |
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| K0000 | <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/23/12</p> <p>Facility Number: 000527 Provider Number: 155578 AIM Number: 100267110</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 V (000)</p> | K0000 | PLEASE ACCEPT THIS PLAN OF CORRECTION FOR DEFICIENCIES FOUND DURING THE LIFE SAFETY CODE INSPECTION CONDUCTED ON 7-23-12 AT MILLER'S MERRY MANOR - NEW CARLISLE. PLEASE ACCEPT THE PLAN OF ACTION AS NOT TO BE CONTRUCTED AS AN ADMISSION OF AGREEMENT WITH THE FINDINGS OR CONCLUSIONS. CORRECTED POC 8-22-12. | |

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>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 62 and had a census of 52 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage of beds, mattresses and maintenance supplies which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K0018 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 5 of 5 office doors protecting corridor openings on the administration hall. This deficient practice could affect any residents evacuated through the administration hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/23/12 at 2:35 p.m., the corridor door to the Social Service office, the Administrator's office, the Director of Nursing's office, the Admissions office and the</p> | K0018 | <p>Magnets will be placed on all 5 of the office doors by a contractor / maintenance supervisor. This will operate to hold the door open automatically and when the fire alarm sounds the doors will all automatically close. All residents will be protected by this correction. The doors will be checked monthly by the Maintenance Supervisor and placed on monthly Preventative Maintenance and monthly Quality Assurance reviews until the facility has this citation back into compliance. This will be corrected by 8-22-12 and monitored with weekly progress by the Administrator.</p> | 08/22/2012 |

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| | <p>Business office were propped open with plastic door wedges. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> | | | |

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| K0025 SS=D | <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 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 in the Inservice office in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/23/12 at 12:59 p.m., there is an unsealed three quarter inch hole alongside the sprinkler head in the Inservice office. This was acknowledged by the Maintenance Director at the time of</p> | K0025 | The unsealed three quarter inch hole alongside the sprinkler head in the Inservice Office. This hole will be repaired by the Maintenance Supervisor on 8-02-12, who will seal it with Intumescent Firestop Sealant. Residents affected will be in a safe environment. This will be placed on the Maintenance monthly Preventative Maintenance and monthly Quality Assurance reviews until the facility has this citation back into compliance. This will be corrected by 8-22-12 and monitored monthly by the Administrator. | 08/22/2012 | | | |

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| | <p>observation.</p> <p>3.1-19(b)</p> | | | |

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| K0038 SS=F | <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 6 of 6 exits were 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 could affect any resident without a medical diagnoses requiring security measures exiting through all of the facility's exits.</p> <p>Findings include:</p> | K0038 | <p>The Maintenance Supervisor has changed the code and posted the code at all 6 exit doors on 8-01-12. All Residents are safe as a result of the posting of the codes. The Maintenance Supervisor will monitor with monthly Preventative Maintenance and monthly Quality Assurance reviews. The two Residents with dementia diagnosis who were at risk are secured. This will be completed by 8-22-12 and monitored monthly by the Administrator.</p> | 08/22/2012 |

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| | <p>Based on observation with the Maintenance Director on 07/23/12 during the tour from 2:35 p.m. to 4:07 p.m., all of the six emergency exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. Based on a telephone conversation with the Administrator on 07/27/12 at 8:15 a.m., two of fifty two residents had a diagnoses requiring specialized security measures.</p> <p>3.1-19(b)</p> | | | | |

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| K0051 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the administration office hall and 1 of 1 smoke detectors in the main nurses' station area were installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient</p> | K0051 | The Maintenance Supervisor (8-06-12) moved the smoke detectors more than 36 inches from all vents. This will eliminate any harm happening to the Residents. The Maintenance Supervisor will monitor and place this citation on the monthly Preventative Maintenance and the monthly Quality Assurance reviews. This will be completed by the Administrator monthly and completed by 8-22-12. | 08/22/2012 | | | |

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| | <p>practice could affect any residents evacuated through the administration hall and near the main nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/23/12 from 2:40 p.m. to 3:12 p.m., the smoke detectors in the administration hall and in the main nurses' station area were located within three feet of a air supply duct. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> | | | | |

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| K0076 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure the electrical fixtures in 1 of 1 oxygen storage rooms were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect any residents near the oxygen transferring room at the north entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on</p> | K0076 | The Maintenance Supervisor moved the electrical light switch in the oxygen room(8-01-12) to greater than 5 feet and the electrical outlet was disconnected and a blank cover placed on the electrical outlet cover. The Maintenance Supervisor has placed this citation on monthly Preventative Maintenance and monthly Quality Assurance reviews until the facility has this citation back into compliance. This will be corrected by 8-22-12 and monitored with weekly progress by the Administrator. | 08/22/2012 | | | |

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| | <p>07/23/12 at 3:21 p.m., the oxygen storage room had two large liquid oxygen storage tanks placed in the room with one electrical switch on the wall forty eight inches above the floor and one electrical receptacle on the wall twelve inches above the floor. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> | | | |

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| K0130 SS=E | <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure penetrations in 2 of 11 fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item</p> | K0130 | <p>#1 The firewall in the 100 hallway had 2 unsealed penetrations around wires measuring one forth inch in size. This firewall was repaired by the Maintenance Supervisor on 8-3-12. It was repaired with Intumescent Firestop Sealant. Maintenance will assure, with monthly Preventative Maintenance and monthly Quality Assurance reviews, that this will not reoccur. If found it will be repaired immediately by the Maintenance Supervisor. This corrected citation assures all residents are in no harm. This will be corrected by 8-22-12 and monitored with weekly progress by the Administrator</p> <p>#2 The rolling fire door in the office area was inspected by an outside contractor, Overhead Door Company on 7-31-12. This will be inspected annually hereafter and documentation will be provided. This will eliminate any danger of residents being evacuated unsafely. The Maintenance Supervisor has placed this citation on monthly Preventative Maintenance and monthly Quality Assurance reviews until the facility has this citation back into compliance. This will be corrected by 8-22-12 and monitored with weekly progress by the Administrator.</p> | 08/22/2012 | | | |

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| | <p>uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affects 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/23/12 at 3:40 p.m., there were two unsealed penetrations around wires measuring one fourth inch in size above the lay in ceiling at the 100 hall fire wall. This wall was confirmed to be a fire wall by the Maintenance Director.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview; the facility failed to ensure the care and</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155578 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/23/2012 |
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| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E DUNN RD NEW CARLISLE, IN 46552 |
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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 |
|--------------------|--|---------------|---|----------------------|
| | <p>maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident evacuated through the administration hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/23/12 at 1:35 p.m., there was a rolling fire door protecting the</p> | | | |

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| | <p>opening from the administration corridor and the reception office. Based on the Overhead Door inspection record, the last annual inspection was conducted on 02/24/11. Based on interview with the Maintenance Director at the time of observation, no other documentation was available for review.</p> <p>3.1-19(b)</p> | | | |