

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
--	---

(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
--------------------	--	---------------	---	----------------------

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: 03/24/14</p> <p>Facility Number: 000163 Provider Number: 155262 AIM Number: 100291380</p> <p>Surveyor: Bridget Brown, 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) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke</p>	K010000		
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882		
(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>detection. The facility has a capacity of 93 and had a census of 83 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The maintenance equipment storage garage was unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
--	---

(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
--------------------	--	---------------	---	----------------------

K010018 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 1¼ 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. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 7 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/24/14 between 10:45 a.m. and 2:30 p.m., double door sets providing access from the corridor to the private dining room and to the physical therapy department each required one door to be latched manually into the door frame before the second</p>	K010018	<p>K 018 NFPA 101 Life Safety Code Standard. The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 018. I. To correct the deficient practice the facility had automatic door latches installed on the doors providing access to the private dining room and to the therapy department from the corridor. II. This deficient practice affects staff, visitors and 10 or more residents in the center smoke compartment. III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Maintenance Supervisor will ensure dining room and therapy doors protecting the corridor can automatically latch into the door</p>	04/03/2014
-----------------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
--	---

(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>door would automatically latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p>		<p>frame. IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1.)The Maintenance Supervisor will ensure doors protecting the corridor can automatically latch into the door frame. V. Maintenance Supervisor will be responsible. Completion Date: 4/3/2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882			
(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			
K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 a door in 1 of 6 smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents in the west smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/24/14 at 11:50 a.m., one door in the smoke barrier double door set accessing the west wing failed to close when tested twice to ensure its proper operation. The door coordinator on the door frame held the door with the astragal open, the second door closed, and the coordinator failed to</p>	K010021	<p>K 021 NFPA 101 Life Safety Code Standard.</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 021.</p> <p>I. To correct the deficient practice the facility repaired the door coordinator on 3/24/2014. In addition, the door coordinator was tested daily from 3/24/2014 to 4/4/2014 and the coordinator functioned properly during every test.</p> <p>II. This deficient practice could affect staff, visitors, and 10 or more residents in the west smoke compartment.</p>	03/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882		
(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>release the first door leaving a six inch gap. The maintenance director acknowledged at the time of observation, the coordinator had malfunctioned.</p> <p>3.1-19(b)</p>		<p>III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) The Maintenance Supervisor will test the door coordinators weekly for one month then monthly thereafter to ensure they are working properly.</p> <p>IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will test the door coordinators weekly for one month then monthly thereafter to ensure they are working properly.</p> <p>V. Maintenance Supervisor will be responsible. Completion Date: 3/24/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882			
(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			
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 provide automatic closers for doors providing access to 1 of 9 hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the east wing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/24/14 at 11:05 a.m., the two doors separating the 12 by 12 foot medical records/nursing supply storage room from the adjacent activities room and the exit corridor each</p>	K010029	<p>K 029 NFPA 101 Life Safety Code Standard.</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 029.</p> <p>I. To correct the deficient practice the facility installed an automatic door closures on the door in medical records that exits into the corridor and on the door between medical records and activities on 3/26/14.</p> <p>II. This deficient practice could affect visitors, staff and 10 or more residents in the east wing smoke compartments.</p>	04/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882		
(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>had no self closing devices. The room was full of medical records piled high on every available surface including the desk, bookcase and a side table. Envelopes of records were stacked upon a six foot length of filing cabinets along one wall to within 16 inches of the ceiling. The same wall had wooden cabinets attached to the wall which contained more records and stored paper and plastic wrapped wound care supplies. Four cardboard cartons of supplies were stacked behind the door separating the room from the exit corridor. The maintenance director acknowledged at the time of observation, the room was used for storage and was so full there was little room the navigate in the space.</p> <p>3.1-19(b)</p>		<p>III. The facility has made systemic changes to ensure the deficient practice does not recur by the following: 1) The Maintenance Supervisor installed automatic door closures on both doors. 2) The Medical Records staff cleaned the office space eliminating piles of medical records and envelopes, and cardboard cartons.</p> <p>IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will ensure the door closures are maintained in place on both doors in medical records. 2.) The Administrator will ensure the Medical Records office is maintained in a clean and organized manner.</p> <p>V. Maintenance Supervisor will be responsible for door closures. Completion Date: 3/26/14 Administrator will be responsible for Medical Records organization: Completion Date: 4/18/14.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2014	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882			
(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			
K010064 SS=C	<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 monthly checks were provided for 16 of 16 portable fire extinguishers. NFPA 10, 4-3.4.2 the Standard for Portable Fire Extinguishers, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/24/14 between 10:45 a.m. and 2:30 p.m., the service and inspection tags on all the portable fire extinguishers each noted the last monthly check had been done 02/14/14. The maintenance director acknowledged at the time of observations, the monthly fire extinguisher checks were overdue.</p> <p>3.1-19(b)</p>	K010064	<p>K 064 NFPA 101 Life Safety Code Standard. The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K 064. I. To correct the deficient practice the facility will ensure portable fire extinguishers are inspected at least monthly. II. This deficient practice could affect all occupants. III. The facility has made systemic changes to ensure the deficient practice does not recur by the following: 1) The Maintenance Supervisor or his designee will inspect portable fire extinguishers at least monthly not to exceed 31 days. IV. The corrective action will be monitored to ensure the deficient practice will not recur by: 1) The Maintenance Supervisor will monitor the inspection records for portable fire extinguishers for the next quarter to ensure those checks are at least monthly. V. Maintenance Supervisor will be responsible. Completion Date: 3/24/14.</p>	03/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155262	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
--	---

(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