

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 04/28/2014
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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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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: 04/28/14</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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000		
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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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K010029 SS=E	<p>capacity of 44 and had a census of 28 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including activity storage and maintenance supplies that were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 Based on observation and interview, the facility failed to ensure the corridor doors</p>	K010029	Please accept the following plan of correction for the deficiency	05/28/2014			

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K010050 SS=C	<p>to 2 of 2 water heater rooms, a hazardous area, closed and latched into the door frame. This deficient practice affects 1 of 3 smoke compartments.</p> <p>Findings includes:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/28/14 at 12:35 p.m., both water heater rooms in the service hall were designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p>		<p>cited under tag K029, which could have affected 1 of 3 smoke compartments. To correct this deficiency, the Maintenance Director will install latches into the frame and assure that the doors close independently. To prevent recurrence of this deficient practice the Maintenance Director will be checking for compliance through monthly function test of the doors.</p> <p>POC will be completed by 5-28-14.</p>				

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	<p>1. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the untitled TEL's program computer generated fire drill forms with the Maintenance Director on 04/28/14 at 1:25 p.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of the last 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the untitled TEL's program computer generated fire drill forms with the Maintenance Director on 04/28/14 at 1:35 p.m., all second shift fire drills took place between 2:17 p.m.</p>	K010050	<p>Please accept the following plan of correction for the deficiency cited under tag K050, which all occupants could have been negatively affected. To correct this deficiency, the Maintenance Director will document in the "comments" section of attachment C, the location as well as the type of fire. The Maintenance Director will also vary the time of the drills by using attachment D. To prevent recurrence of this deficient practice the Maintenance Director will be checking for compliance through monthly drills as well as quarterly that the documentation is in place.</p> <p>POC will be completed by 5-28-14.</p>	05/28/2014	

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K010064 SS=D	<p>and 4:00 p.m. for four of the last four quarters and all third shift fire drills took place between 10:30 p.m. and 11:10 p.m. for four of the last four quarters. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <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 Based on observation and interview, the facility failed to inspect 1 of 1 Beauty shop fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its</p>	K010064	Please accept the following plan of correction for the deficiency cited under tag K064, which one resident could have been negatively affected. To correct this deficiency, the Maintenance Director will inspect the function of the Beauty Shop fire extinguisher monthly and document on attachment B. To prevent recurrence of this deficient practice the Maintenance Director will be checking for compliance through monthly inspections as well as quarterly that the documentation is in place.	05/28/2014

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K010130 SS=C	<p>designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect 1 resident in the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/28/14 at 12:09 p.m., the monthly inspection tag for the fire extinguisher in the Beauty Shop lacked documentation of a monthly inspection for March 2014. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 21 of 21 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient</p>	K010130	<p>POC will be completed by 5-28-14.</p> <p>Please accept the following plan of correction for the deficiency cited under tag K130, which all residents, visitors and staff could have been negatively affected. To correct this deficiency, the Maintenance Director will check the function of the smoke detectors monthly and document on attachment A. To prevent</p>	05/28/2014			

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	<p>practice affects all residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/28/14 during the tour from 11:40 p.m. to 1:30 p.m., each resident room had a battery operated smoke detector. Based on an interview with the Maintenance Director during the record review process on 04/28/14 at 1:18 p.m., he was unable to provide documentation to confirm a monthly function test was conducted on the battery operated smoke detectors for the month of March 2014.</p> <p>3.1-19(b)</p>		<p>recurrence of this deficient practice the Maintenance Director will be checking for compliance through monthly function test as well as quarterly that the documentation is in place.</p> <p>POC will be completed by 5-28-14.</p>		