

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573
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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: 08/13/13</p> <p>Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980</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) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000	Please accept this Plan of Correction as our Credible Allegation of Compliance.	

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>capacity of 120 and had a census of 115 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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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 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. Based on observation and interview, the facility failed to ensure 1 of 1 pairs of Activity room corridor doors would close and latch into the door frame. This deficient practice could affect approximately 6 residents in the Activity room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/13/13 at 2:03 p.m., the Activity room has 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 into the door frame automatically</p>	K010018	No residents were adversely affected by this deficiency. Any resident within the Activity Room, or within proximity to the Activity Room, could have had the potential to be adversely affected by this deficiency during a fire emergency situation. One door of the double door set will be constructed to be permanently attached to the door frame & floor. The other door will latch into the door frame, thus eliminating the concern related to this deficiency. We consulted with an outside vendor, Safe Care, & will follow their recommendation, as stated previously, to resolve this concern. A review of this new door arrangement will be monitored using a Quality Assurance form (see Attachment A) on a quarterly basis by the Maintenance Supervisor, or a	09/12/2013			

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	and independent of the other door. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)		designee, to ensure proper functioning ongoing. Any concerns will be fixed immediately & will be noted during the next Quality Assurance meeting.		

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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 ensure the corridor door to 2 of 2 shower rooms used for storage of soiled linen, thus creating a hazardous area, were provided with a door that would self close and latch into the frame. This deficient practice could affect two of five smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 08/13/13 from 1:45 p.m. to 2:05 p.m., both station 1 and station 2 shower rooms' corridor door lacked self closing devices. Each had one barrel, one half full of soiled clothing and one barrel, one half full of towels. Based on an interview with the Maintenance Supervisor at the time of observations, the soiled linen barrels are stored in the shower rooms until collected</p>	K010029	No residents were adversely affected by this deficiency. Any resident within the Shower Room, or within proximity of the Shower Room, could have had the potential to be adversely affected by this deficiency during a fire emergency situation. Self closing devices were installed on both shower room doors on 8/15/13. A review of the shower room door closers will be monitored using a Quality Assurance form (see Attachment A) on a quarterly basis by the Maintenance Supervisor, or designee, to ensure proper functioning ongoing. Any concerns will be fixed immediately & will be noted during the next Quality Assurance meeting.	08/15/2013			

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	by someone from the laundry and taken to the laundry room. 3.1-19(b)				

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K010056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 Information Technology (IT) closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/13/13 at 2:00 p.m., the IT closet in the Admission's office lacked sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observation.</p>	K010056	No residents were adversely affected by this deficiency. Any residents within the Admissions Office, or near the Admissions Office/IT Closet, could have had the potential to be adversely affected by this deficiency in the event of a fire emergency situation. A sprinkler head was installed in the IT Closet, within the Admissions Office, on 8/20/13 by an outside vendor, Safe Care, & is now fully operational (see Attachments B & C). The installation of the sprikler head in the IT Closet, within the Admissions Office, will now alleviate this concern once & for all & will not require further monitoring in the future.	08/20/2013			

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	3.1-19(b)				

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K010130 SS=D	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure 1 of 4 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/13/13 at 2:45 p.m., the water heater in the station 1 mechanical room was installed on 08/2012 but lacked a registration number. Based on record review and interview with the Maintenance Supervisor at the time of observation, the Certificate of Inspection at the water heater was for an old water heater that had been removed. He was unable to provide a Certificate of Inspection for the new water heater.</p> <p>3.1-19(b)</p>	K010130	<p>No residents were adversely affected by this deficiency. The new water heater was installed in August of 2012 & was later inspected by a member of the Indiana Department of Homeland Security, but a Certificate of Inspection was never obtained by this facility to prove that the new water heater was inspected. A member of the Indiana Department of Homeland Security inspected the water heater on 8/19/13 & indicated that the water heater passed inspection (see Attachment D). We now are in the process of obtaining the Certificate of Inspection from the Indiana Department of Homeland Security & when this Certificate is received, it will be displayed near the location of the water heater & remain in that location until the next inspection within the next 2 years per State requirement. This inspection, along with the subsequent display of the Certificate, will alleviate this concern & will not require further monitoring in the future.</p>	09/12/2013	

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