STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

(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	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). Survey Date: 02/11/14 Facility Number: 000196 Provider Number: 155299 AIM Number: 100267390 Surveyors: Mark Caraher, Life Safety Code Specialist & Libby Fruth, Life Safety Code Specialist 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the	K010000	We ask that the responses below will warrant a desk review for the citations received. Sincerely,Jimmy Grimes H.F.A	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	corridor. The facility has battery operated smoke detectors in all 36 resident sleeping rooms. The facility has a capacity of 66 and had a census of 63 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=E	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of over 75 corridor doors had no impediment to closing or latching and would resist the passage of smoke. This deficient practice could affect 10 residents, staff and visitors in the Physical Therapy Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the corridor set of entry doors to the Physical Therapy Room were each held wide open with a wedge, were not provided with a positive latching device to ensure the door would	K010018	The two corridor doors identified during the survey process have been corrected to ensure doors latch into door frame, and the gap corrected to resist passage of smoke.All residents are at risk to be affected by deficient practice. All facility staff will be in-serviced on or by 3/7/13 regarding the importance of not propping any facility corridor doors open. The facility administrator and maintenance director will continue to make routine walking rounds of the facility to ensure doors are not propped open.The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality	03/13/2014

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	latch into the door frame, and there was a three quarter inch wide gap between the closed doors which were not equipped with an astragal, rabbet or bevel to resist the passage of smoke. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor doors to the Physical Therapy Room were each propped in the fully open position with a wedge, were not equipped with a positive latching mechanism to latch each door into the door frame and were not equipped with an astragal, rabbet or bevel to resist the passage of smoke. 3.1-19(b)		assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	

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K010025 SS=F	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 1. Based on observation and interview, the facility failed to ensure openings through 3 of 11 smoke barrier walls and 1 of 1 Therapy Room closet smoke barrier walls were protected to maintain the one half hour fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of	K010025	Safe Care has completed an onsight assessment of the needed repairs and a P.O. has been issued to have smoke barrier walls, therapy room closet walls, and the ceiling smoke barrier is protected to ensure one half hour fire resistance of the smoke barrier wall and the ceiling.All residents are at risk to be affected by the deficient practiceRepairs will be completed by 3/13. The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	03/13/2014

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	the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the following openings were noted which did not provide at least a one half hour fire resistance rating for the smoke barrier wall: a. the one inch annular space surrounding three separate three inch in diameter conduits for the passage of cables in the smoke barrier wall above the ceiling by the smoke barrier door set by Room 101. b. the one inch annular space surrounding three separate three inch in diameter conduits for the passage of cables in the smoke barrier wall above the ceiling by the smoke barrier door set by Room 201. c. a one inch in diameter open ended conduit and a two inch in diameter open ended conduit for the passage of a cable through the smoke barrier wall above the ceiling by the smoke barrier door set by Room 301. d. a one inch in diameter hole for the passage of one cable in the north wall of the Physical Therapy Room closet which contained natural gas fired furnaces. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned openings in smoke barrier walls did not provide at least a one half hour fire resistance rating.			

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors in the Physical Therapy Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the following openings in the ceiling smoke barrier of the furnace room in the Physical Therapy Room were noted which did not provide at least a one half hour fire resistance rating for the ceiling smoke barrier: a. two separate one foot by four inch rectangular openings in the ceiling between furnace ductwork exposed wood studs in the attic above. b. the two inch annular space surrounding two, four inch in diameter PVC pipes penetrated the suspended ceiling. c. two, one inch in diameter pipes for the passage of cables penetrated the furnace room ceiling. Based on interview at the time of the observations, the Maintenance			

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	Supervisor acknowledged the aforementioned openings did not provide at least a one half hour fire resistance rating. 3.1-19(b)			
K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 10 smoke barrier doors would provide a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance and shall be without undercuts. This deficient practice could affect 22 residents, staff and visitors if smoke was allowed to move from the 300 Hall smoke compartment to another smoke compartment.	K010027	The 300 Hall smoke barrier door leading to physical therapy and assisted living have been corrected with an clear anodized Alum. with sponge Neoprene insert. BHMA certified to ensure a smoke resistant barrier when door is closed. The self closing door to the furnace room has been corrected with a self closing closer. All residents are at risk to be affected by the deficient practiceThe QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly	03/13/2014

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the 300 Hall smoke barrier door leading to Physical Therapy and assisted living had an undercut which measured one inch at the latch side and one and one quarter inches at the hinge side when closed which failed to provide a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the 300 Hall smoke barrier door leading to Physical Therapy and assisted living had an undercut of one inch or more which failed to provide a smoke resistant barrier when the door was closed. 3.1-19(b)		x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	

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K010029 SS=E	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 1. Based on observation and interview, the facility failed to ensure ensure 1 of 7 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 10 residents, staff and visitors in the Physical Therapy Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the following openings in the wall and ceiling smoke barriers of the furnace room in the Physical Therapy Room were noted which did not separate this hazardous area from other spaces by smoke resistant partitions: a. two separate one foot by four inch	K010029	The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	03/13/2014

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	rectangular openings in the ceiling between furnace ductwork exposed wood studs in the attic above. b. the two inch annular space surrounding two four inch in diameter PVC pipes penetrating the suspended ceiling was not smoke resistant. c. two, one inch in diameter pipes for the passage of cables penetrated the ceiling and were not smoke resistant. d. a one inch in diameter hole in the north wall for the passage of one cable was not smoke resistant. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned openings in the smoke barrier wall and ceiling of the furnace room in the Physical Therapy Room did not not separate this hazardous areas from other spaces by smoke resistant partitions. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 7 doors serving hazardous areas such as fuel fired heater rooms are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 10 residents, staff and visitors in the Physical Therapy Room.			

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., the Physical Therapy Room furnace room contained two furnaces and one water heater which were each natural gas fired and the entry door was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the furnace room entry door from the Physical Therapy Room was not equipped with a self closing device to close and latch the door into the door frame. 3.1-19(b)			
K010038 SS=F	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			

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	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 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 all residents, staff and visitors. Findings include: Based on observation on 02/11/14 with the Maintenance Director during the tour from 11:10 a.m. to 2:30 p.m., four of the five exit doors in the resident pods were magnetically locked and could be opened by entering a code. The employee exit is marked with an exit sign but did not have the code posted. Based on interview during the exit conference at 2:30 p.m. on 02/11/14, the Administrator stated not all residents	K010038	The code to the employee exit door has been posted. All residents are at risk to be affected by the deficient practice.The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	03/13/2014

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	have a clinical diagnosis to be in a secure building and acknowledged the exit access code was not posted at the employee exit. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b)			
K010050 SS=F	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 Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include:	K010050	The facility will have a fire drill each quarter for all three shifts. Each drill be completed at varied times each quarter for each shift drill.All residents are at risk to be affected by the deficient practice.The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then	03/13/2014

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	Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 8:50 a.m. to 11:10 a.m. on 02/11/14, documentation of a fire drill conducted on the third shift for the fourth quarter of 2013 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated no other third shift, fourth quarter 2013 fire drill documentation was available for review and acknowledged documentation of a fire drill conducted on the third shift for the fourth quarter of 2013 was not available for review. 3.1-19(b)		weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	

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MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

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K010074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on record review, observation and interview; the facility failed to ensure 2 of 2 window curtains in the reception area were flame retardant. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room near the reception area. Findings include: Based on record review with the Maintenance Supervisor from 8:50 a.m. to 11:10 a.m. on 02/11/14, documentation of the flame spread rating of reception area window curtains was not available for review. Based on observation with the Maintenance	K010074	The manufacturer's fire retardant rating for the curtains has been obtained. The documentation of the curtain flame spread rating will be maintained in a file by the administrator.All residents are at risk to be affected by the deficient practice.The administrator will be responsible to maintain a file with the flame spread rating for facility curtains which can be readily accessed upon request. The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues will be corrected upon discovery and logged on facility quality	03/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155299		02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

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	Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., two sets of window curtains in the reception sitting area did not have attached documentation indicating they were inherently flame retardant or had been treated with a flame retardant material. Based on interview at the time of record review and of the observation, the Maintenance Supervisor stated the window curtains are not treated with a flame retardant material and acknowledged documentation regarding flame spread rating of the reception area window curtains was not available for review.		assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. 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	K010130	SafeCare has completed an inspection/testing of the kitchen rolling fire door on operation and documentation will be maintained as evidence that the testing is done at least annually. All residents at risk to be affected by the deficient practice.The QA tool titled "Life Safety Review" will be completed daily by the maintenance director or other designee x 1 week, then weekly x4 weeks then monthly thereafter. Any identified issues	03/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368	

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	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 30 residents, staff and visitors in the Main Dining Room. Findings include: Based on record review with the Maintenance Supervisor from 8:50 a.m. to 11:10 a.m. on 02/11/14, documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility on 02/11/14 from 11:10 a.m. to 2:30 p.m., there was a rolling fire door protecting the opening between the kitchen serving area and the Main Dining Room and the affixed hanging tag indicated the most recent inspection and test was performed by SafeCare in January 2013. Based on interview at the time of observation, the Maintenance Supervisor acknowledged documentation of an annual inspection and test within the most recent twelve month period was not available for review.		will be corrected upon discovery and logged on facility quality assurance tracking log. The facility reviews QA tracking logs during the monthly QA meeting to monitor for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014

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	3.1-19(b)			