

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155006		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 N ALBER ST WABASH, IN46992			
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K0000	<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: 09/29/11</p> <p>Facility Number: 000006 Provider Number: 155006 AIM Number: 100290220</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 (111) construction and was fully</p>			K0000			

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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K0025 SS=E	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 84 and had a census of 68 at the time of this survey.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/30/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 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 hour fire resistance rating. LSC 8.3.2 requires smoke barriers</p>	K0025	It is the policy of Millers Merry Manor Wabash East, to ensure that all ceiling smoke barriers are maintained to provide a one hour fire resistance rating. K-0025I. The 5/8 inch drywall ceiling panel in room 117 was replaced by a metal panel on 10/3/2011. II. All	10/27/2011	

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K0061 SS=F	<p>shall be continuous from an outside wall to an outside wall. This deficient practice could affect any of the 52 residents on the East hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Maintenance Assistant and the Housekeeping/Laundry Supervisor on 09/29/11 at 1:30 p.m., the attic access panel in resident room 117 was made from a single layer of five eights inch drywall. The entire building has a one hour fire rated smoke barrier ceiling. Based on an interview with the Maintenance Assistant at the time of observation, the facility is planning to replace the attic access panel with one made of metal.</p> <p>3.1-19(b) Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 PIV (post indicator valve) was electronically</p>	K0061	<p>52 of the residents on the East Hall have the potential to be affected by this deficient practice, A facility wide audit was done on 10/3/2011 by the Maintenance Director to ensure that were no other areas of non-compliance. See Attic panel audit tool (exhibit A pg#1). III. Maintenance will do a weekly QA audit, using QA tool (exhibit A pg #2) for 3 months, then monthly thereafter for 6 months, any findings will be addressed immediately.IV. The Maintenance director or Designee will bring the QA tool to the monthly QA meetings for review by the QA committee, this will continue for 6 month and then as QA committee deems needed.V. Date of Completion: 10/27/11</p> <p>K-0061It is the policy of Millers Merry Manor to have sprinkler system valves supervised so a local alarm will sound when the valves are closed.I. A electronic</p>	10/27/2011	

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K0062 SS=F	<p>supervisor. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant on 09/29/11 at 11:35 p.m., the PIV was in the open position and a breakable lock had been installed by SafeCare on 09/22/11. No electronic tamper device was observed on the PIV. Based on an interview with the Maintenance Supervisor and the Maintenance Assistant at 12:30 p.m., the Maintenance Supervisor stated the PIV was part of the sprinkler system.</p> <p>3.1-19(b) Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, the facility failed to ensure the spray pattern for 2 of 3 sprinkler heads were unobstructed in the East hall housekeeping room and the shower room. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained</p>			K0062	<p>tamper device will be installed to the PIV system on 10/27/11, per Safecare (exhibit B) II. All residents have the potential to be affected.III. The Maintenance Director or Designee will monitor the electronic alarm device, weekly x's one month, then monthly thereafter, using QA tool (exhibit B, pg #2 of 2), for 6 months.IV. The QA tool audits will be brought to the monthly QA meetings for review by the QA committee for 6 months, to ensure compliance.V. Date of Correction: 10/27/11</p> <p>K-0062It is the policy of Millers Merry Manor, Wabash East to ensure that the facility have sprinkler systems that are maintained in reliable operating condition and are inspected, and are un-obstructed.I. The lights in the East Hall housekeeping room and in the East hall shower room were moved on 10/11/11 to</p>		10/27/2011

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	<p>in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any of the 52 residents on the East hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Maintenance Assistant and the Housekeeping/Laundry Supervisor on 09/29/11 from 12:17 p.m. to 12:21 p.m., a ceiling light fixture obstructed the spray pattern of one of one sprinkler heads in the East hall housekeeping room and one of two sprinkler heads in the East hall shower room. Based on an interview with the Maintenance Supervisor at the time of observations, the sprinkler heads were mounted four inches from the ceiling light fixtures.</p> <p>3.1-19(b)</p>		<p>ensure that the sprinkler spray patterns are unobstructed.II. This deficient practice could potentially affect any of the 52 residents on East Hall. An audit was done on 10/7/11 per facility maintenance, using the QA tool (exhibit C pg #1 of 2) to audit the West Hall of the facility, to ensure that no other residents were affected.III. A audit tool will be done monthly by the Maintenance Director or Designee, to ensure that facility sprinkler heads are un-obstructed. (exhibit C pg#2 of2) IV. The QA tool will be brought to the monthly QA meetings for committee review, monthly for 6 months then Quarterly thereafter.V. Date of completion: 10/27/11</p>		

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K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any residents in the East hall lounge.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor, Maintenance Assistant and the Housekeeping/Laundry Supervisor on 09/29/11 at 12:02 p.m., a</p>	K0143	<p>K-143It is the policy of Millers Mewrry Manor, Wabash East to ensure that the transferring of Oxygen occurs where it is separated from the resident housing unit.I. The magnetic strip was immediately removed from the the Oxygen door stricker plate.II. All residents on the East hall have the potential to be affected by the deficient practice.III. A mandatory all staff re-education session for the Transfer and Storage of oxygen will take place on 10/22/11. (exhibit G pg #1) sig: sheet. Maintnace director or Designee will check the oxygen room storage door to ensure that the door is latching, and closed.IV. Maintenance Director or Designee will, audit the oxygen room door and area using the QA audit tool (D pg #2 of 2) daily for 1 month, then weekly for 6 months. The QA tool will be brought to the</p>	10/27/2011	

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	<p>small magnetic no smoking sign was used over the striker plate of the door jam of the oxygen transferring room door in order to prevent the door from latching into the frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>monthly QA committee meetings by the Maintenance Director for review by the QA committee to ensure compliance is achieved.V. Date of Correction: 10/27/11</p>		