

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 11/28/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W WOLFE ST SULLIVAN, IN 47882
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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: 11/28/12</p> <p>Facility Number: 000163 Provider Number: 155262 AIM Number: 100291380</p> <p>Surveyor: Bridget Brown, Life Safety Code Survey 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</p>	K0000	Please see cover letter which was uploaded in supporting documents.	

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>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 detection. The facility has the capacity for 93 and had a census of 86 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 12/04/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0029 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 2 of 12 doors to hazardous areas such as the kitchen closed automatically or upon activation of the fire alarm system.</p> <p>Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 10 or more residents in the adjacent smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director and administrator on 11/28/12 at 1:30 p.m., the self closing corridor</p>	K0029	<p>K 029 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 029. I. To correct the deficient practice the facility installed self closing door closures on the door separating the kitchen from the adjacent dining room and on the door of the dietary manager's office. II. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent smoke compartments. III. The facility has made systemic changes to ensure that the deficient practice does not recur by the following: 1) Maintenance Supervisor will ensure doors to hazardous areas are self closing and latch in the door frame when closed. IV. The corrective action will be monitored to ensure the deficient practice will not recur by:</p>	12/07/2012	

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	<p>door separating the kitchen from the adjacent dining room failed to self close into the door frame. The administrator acknowledged at the time of observation the door was not closing fully.</p> <p>b. Based on observation with the maintenance director and administrator on 11/28/12 at 2:15 p.m., the dietary managers office was located adjacent to the kitchen. A sliding window opening between the kitchen and the office could be closed by manually closing the window. At the time of observation, the window was open to the unoccupied office and the door separating the office from corridor was not equipped with a self closer. The administrator agreed at the time of observation, the kitchen was not properly separated from the dietary manager's office and the corridor.</p> <p>3.1-19(b)</p>		<p>1) The Maintenance Supervisor will ensure doors to hazardous areas are self closing and latch in the door frame when closed to keep the door tightly closed. The Maintenance Supervisor will monitor the doors monthly to ensure they operate properly. V. Maintenance Supervisor will be responsible. Completion Date: 12/7/12.</p>		

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