

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155557	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218
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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: 07/21/14</p> <p>Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220</p> <p>Surveyor: Mark Caraher, 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 facility with a two story center section and two one story wings 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 corridor. The</p>	K010000	<p>July 31, 2014</p> <p>Kim Rhodes Director, Long Term Care Division Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204</p> <p>Re: Survey Event ID KBK21</p> <p>Please accept the enclosed plan of correction as credible allegation of compliance to the deficiencies cited during out Annual Life Safety Code Survey conducted on July 21, 2014, at Millers Merry Manor in Indianapolis.</p> <p>Hopefully, you will find that our remedies are both</p>	
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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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K010015 SS=E	<p>facility has battery operated smoke detectors in all 61 resident sleeping rooms. The facility has a capacity of 114 and had a census of 67 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/24/14.</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 Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1,</p>		<p>sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, we are requesting <i>paper compliance</i>.</p> <p>If, after reviewing our plan of correction, you have any questions or require further information, please do not hesitate to contact me at your convenience at (317) 357 8040.</p> <p>Respectfully submitted,</p> <p>Paula Juday Administrator</p>	

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	<p>19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 75 rooms. This deficient practice could affect 4 residents, staff and visitors in the vicinity of the sprinkler riser room closet in the Salon.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 12:50 p.m. on 07/21/14, the back wall of the sprinkler riser room closet in the Salon was missing an eight foot by three foot section of drywall which exposed six wood studs. In addition, a four foot by three foot section of the ceiling of the aforementioned room was missing which exposed wood studs in the attic above. Based on interview at the time of observation, the Maintenance Assistant acknowledged flame spread rating documentation was not available for review for the exposed wood studs in the sprinkler riser room closet in the Salon.</p> <p>3.1-19(b)</p>	K010015	<p>K015 NFPA 101 LIFE SAFETY CODE STANDARD This deficient practice has the potential to affect residents, staff, and visitors in the vicinity of the sprinkler riser room closet in the Salon. To correct this deficient practice, this facility will do the following:</p> <ul style="list-style-type: none"> · The back wall of the sprinkler riser room closet was dry walled to cover all exposed wood studs and all open areas of the wall (completed 7/30/14). · The ceiling of the sprinkler riser room closet was added to cover all exposed wood studs and all open areas of the ceiling (completed 7/30/14). To prevent recurrence of this deficient practice, the Maintenance Director will continue to make daily (M-F) rounds in the facility, looking for other noncovered areas (Attachment A). This QA tool will be utilized daily (M-F) X 1 week, weekly X 4, monthly X3, and quarterly X2. These corrections were completed by 7/31/14. 	07/31/2014			

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K010025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain the 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</p>	K010025	<p>K025 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>This deficient practice has the potential to affect residents, staff, and visitors in the vicinity of the sprinkler riser room closet in the Salon.</p> <p>To correct this deficient practice, this facility will do the following:</p> <ul style="list-style-type: none"> The ceiling of the sprinkler riser room closet was added to cover 	07/31/2014
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	<p>designed for the specific purpose. This deficient practice could affect 4 residents, staff and visitors in the vicinity of the sprinkler riser room closet in the Salon.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 12:50 p.m. on 07/21/14, a four foot by three foot section of the ceiling of the sprinkler riser room closet in the Salon was missing which exposed the attic above and failed to maintain the smoke resistance of the ceiling smoke barrier. Based on interview at the time of the observation, the Maintenance Assistant acknowledged the aforementioned opening failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>all exposed wood studs and all open areas of the ceiling (completed 7/30/14).</p> <p>To prevent recurrence of this deficient practice, the Maintenance Director will continue to make daily (M-F) rounds in the facility, looking for other noncovered smoke barriers (Attachment A). This QA tool will be utilized daily (M-F) X 1 week, weekly X 4, monthly X3, and quarterly X2.</p> <p>These corrections were completed by 7/31/14.</p>	

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K010038 SS=E	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 10 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 12:50 p.m. on 07/21/14, the electromagnetic lock on the facility exits to the exterior of the building at the Main Entrance, by Room 208, by Room 210 and by Room 234 did not remain unlocked when the fire alarm was activated at 12:17 p.m. After</p>	K010038	<p>K038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>This deficient practice has the potential to affect residents, staff, and visitors.</p> <p>To correct this deficient practice, this facility will do the following:</p> <ul style="list-style-type: none"> Safe Care contacted and came in to check all doors and preform maintenance. All doors are currently working (Attachment B). Maintenance completed on doors on 7/22/14 and 7/30/14 (Attachment B). Delayed Egress doors were tested and maintained by Safe Care on 7/22/14 and 7/30/14. All delayed egress doors had appropriate signage added on 7/31/14. <p>To prevent recurrence of this deficient practice, the Maintenance Director will preform testing of all fire exit doors (Attachment C). This QA tool will be utilized weekly X 4 and bi-weekly thereafter.</p> <p>These corrections will be completed by 7/31/14.</p>	07/31/2014			

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	<p>activation of the fire alarm system at 12:17 p.m. and subsequent silencing of the system, all electromagnetic locks in the building remained unlocked except at the aforementioned four locations. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the aforementioned electromagnetic locks did not remain unlocked while the fire alarm system was activated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that</p>			

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	<p>shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 12:50 p.m. on 07/21/14, the exit doors by Room 208 and by Room 234 to the exterior of the building are each marked as a facility exit, are equipped with a delayed egress lock but each exit was not provided with</p>			

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K010147 SS=E	<p>necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. Each exit door released within 15 seconds when the door was pushed with the application of force two separate times. Based on interview at the time of the observations, the Maintenance Assistant stated the aforementioned exits are each a facility exit, are each equipped with a delayed egress lock but acknowledged each exit was not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring.</p>	K010147	<p>K0147 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>This deficient practice has the</p>	07/31/2014

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	<p>NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Ice Room by the South Nurses Station.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 12:50 p.m. on 07/21/14, a microwave oven and a refrigerator were plugged into a power strip in the Ice Room by the South Nurses Station. Based on interview at the time of observation, the Maintenance Assistant acknowledged a power strip was being used as a substitute for fixed wiring in the Ice Room by the South Nurses Station.</p> <p>3.1-19(b)</p>		<p>potential to affect residents, staff, and visitors.</p> <p>To correct this deficient practice, this facility will do the following:</p> <ul style="list-style-type: none"> The power strip was immediately removed and refrigerator plugged directly into wall, with microwave being removed from the room (completed July 21, 2014). <p>To prevent recurrence of this deficient practice, the Maintenance Director will continue to make daily (M-F) rounds to look for power strips and remove immediately if located (Attachment A). This QA tool will be utilized daily (M-F)X1 week, weekly X 4, monthly X3, and quarterly X2.</p> <p>These corrections will be completed by 7/31/14.</p>		