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 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1651 N CAMPBELL ST INDIANAPOLIS, IN 46218

(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
K 0000 Bldg. 01	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: 08/27/15 Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220 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 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 facility has battery operated smoke detectors in all 60 resident sleeping	K 0000	Please accept the enclosed plan of correction as credible allegation of compliance to the deficiencies cited during our most recent Indiana State Department of Health Survey. Hopefully, you will find that our remedies are both 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 a desk review for paper compliance. 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.	

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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	rooms. The facility has a capacity of 114 and had a census of 61 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.			
K 0025 SS=E Bldg. 01	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 1 of 6 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:40 a.m. to 12:50 p.m. on 08/27/15, the smoke barrier wall in	K 0025	K- 25 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices; No residents were affected by the deficient practice. The smoke barrier wall in the attic above the horizontal attic access door in the south wall of the second floor conference room	09/17/2015

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	the attic above the horizontal attic access door in the south wall of the second floor conference room had a four foot long by six inch high section of two layers of drywall missing on the attic side of the wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned section of missing drywall failed to maintain the smoke resistance of the attic smoke barrier wall. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:40 a.m. to 12:50 p.m. on 08/27/15, a sixteen inch by ten inch "L" shaped section of ceiling tile for the passage of over 25 data cables was missing in the first floor computer room by the Admissions Office. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned location had a section		was repaired with a four foot by six inch high section to include two layers of drywall on the attic side of the wall. The “L” shaped section of ceiling tile for the passage of data cables was replaced and sealed with fire rated caulk in the first floor computer room by the Admissions Office. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other residents have the potential to be affected by this deficient practice. The smoke barrier wall in the attic above the horizontal attic access door in the south wall of the the second floor conference room was repaired with a four foot by six inch high section to include two layers of drywall on the attic side of the wall . The “L” shaped section of the ceiling tile for the passage of data cables was replaced and sealed with fire rated caulk in the floor computer room by the Admissions Office. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director and/or designee will complete the QA tool	

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	of ceiling tile missing which would not maintain at least a one half hour fire resistance rating for the ceiling smoke barrier. 3.1-19(b)		titled, "Fire Penetration and Egress " monthly and then monthly thereafter for ongoing compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Any identified issues will be corrected upon discovery and logged on the facility QA tracking log. QA trackers are reviewed monthly as part of the facility's monthly QA meeting for ongoing compliance. By what date the systemic changes will be completed. 9/17/2015	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 2 of 10 exits means of egress. This deficient practice could affect 30 residents, staff and visitors.	K 0072	K- 72 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. What corrective action(s) will be accomplished for those residents found to have been affected by the	09/17/2015

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	Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:40 a.m. to 12:50 p.m. on 08/27/15, the following was noted: a. a three foot high by two foot wide plastic chest of drawers used to store personal protective equipment and supplies for a resident's isolation equipment was stored in the corridor outside Room 206. The aforementioned three drawer chest of drawers was placed against the corridor wall and protruded eighteen inches into the corridor outside the room. b. seven plastic milk crates, a wooden chair and two cardboard boxes were stored in the exit access corridor from the main dining room to the outside of the building by the kitchen entrance. The aforementioned exit access corridor was marked as a facility exit. The corridor storage limited the clear width of the corridor to three feet where the items were stored. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use at the aforementioned locations.		deficient practices; No residents were affected by this deficient practice. The three foot high by two foot wide plastic chest used for Personal Protective Equipment was removed from the corridor outside of resident room 206. The seven plastic milk crates, a wooden chair and two cardboard boxes were removed from the service hall corridor removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Other residents have the potential to be affected by this deficient practice. The three foot high by two foot plastic check used for Personal Protective Equipment was removed from the corridor outside of the resident room 206. The seven plastic milk crates, a wooden chair, and two cardboard boxed were removed from the service hall corridor were removed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director and/or designed will completed the facility QA tool titled, “Fire Penetration and Egress” monthly and then monthly	

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	3.1-19(b)		thereafter to ensure ongoing compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Findings will be corrected upon discovery and logged on the QA tracker log. The QA trackers are reviewed monthly as part of the facility's QA meeting for ongoing compliance. By what date the systemic changes will be completed. 9/17/2015	