STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	259 W HARRISON ST MOORESVILLE, IN 46158

(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: 04/14/16 Facility Number: 000398 Provider Number: 155564 AIM Number: 100291110 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 III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has battery operated smoke detectors in 49 of 49 resident sleeping rooms. The facility has a capacity of 98 and had a census of 50 at the time of this	K 0000	Dear Mrs Rhoades Please accept the enclosed plan of correction as credible allegation of compliance for the deficiencies cited during our life safety code survey conducted on April 14th, 2016 at the Miller's Merry Manor in Mooresville, Indiana Hopefully you will find out remedies correct the concerns We respectfully ask for consideration for paper compliance Feel free to contact me at 317-831-6272 with any questions you may have Thank you, Lindsey Hart Executive Director Miller's Merry Manor-Mooresville 317-831-6272	

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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	survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/19/16 - DA			
K 0014 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, 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. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Based on observation and interview, the facility failed to ensure interior finish installed in 2 of 6 corridors serving as an exit or exit component had a flame spread rating of Class A or Class B. This deficient practice could affect 12 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on	K 0014	It is the policy of Miller's Merry Manor that interiorfinish for means of egress, including exposed interior surfaces of buildingssuch as fixed or movable walls, partitions, columns, and ceilings has a flamespread rating of Class A or Class B. All residents havethe potential to be affected by this practice. On 4/18/2016 a flame retardant paint was ordered. Theparticle board on Harrison was painted with this paint on 4/25/2016. The woodparticle board on the Carrie hallway has been removed since	04/25/2016

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	04/14/16, a wooden particle board wall was constructed from floor to ceiling to block off a portion of the Harrison Hall corridor by Room 6 to keep residents and visitors from entering that portion of the corridor during renovation. In addition, a wooden particle board wall was also constructed from floor to ceiling to block off the Carrie Hall corridor by Room 22 to keep residents and visitors from entering that portion of the corridor during renovation. A wooden particle board wall was also constructed in Carrie Hall by Rooms 16 and 17 to keep residents and staff from entering those rooms during construction. Based on interview at the time of observation, the Maintenance Director stated the particle board walls were not treated with a fire retardant material and acknowledged the flame spread rating for the particle board interior finish used in the aforementioned corridors serving as an exit or exit component was not available for review. 3.1-19(b)		survey and there isno longer particle board in that area. The wooden particle board wall on Carriehall by rooms 16 & 17 was also painted on 4/25/2016 with the fire retardantpaint. Education was provided to themaintenance director, the maintenance assistant director, and the constructionteam manager that if any other type of temporary wall is installed it will needto be also treated with a flame spread rating of Class A or Class B treatment.The construction team and maintenance staff were educated that if anymoretemporary particle board is put up it will need to be treated at that time withthe fire resistant paint or spray with a rating of Class A or Class B. Allsystematic changes were completed on 4/25/16.	
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door			

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	and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the Environmental Services Office in Pioneer Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, a one quarter inch hole was noted above the door handle in the corridor door to the Environmental Services Office in Pioneer Hall which would not resist the passage of smoke. In addition, a three quarter inch gap was noted in between the door and the door stop near the top of the door frame on the handle side of the door which would also	K 0018	It is the policy of Miller's Merry Manor that doorsprotecting corridor openings in other than required enclosures of verticalopenings, exits, or hazardous areas shall be substantial doors, such as thoseconstructed of 13/4 inch solid-bonded core wood or capable of resisting firefor at least 20 minutes. Clearance between the bottom of door and floor coveringis not exceeding 1 inch. This deficient practice could affect 12 residents, staff andvisitors in the vicinity of the Environmental Services office on Pioneer Hall. A quote has been received (AttachmentA) to replace door and new door is expected to be installed and corrected by5/14/2016. The door was ordered on 4/28/2016. Once the door is replaced thisdeficient practice will be resolved and will not need monitored. All systematicchanges will be corrected and completed by	05/14/2016

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	not resist the passage of smoke. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door would not resist the passage of smoke. 3.1-19(b)		5/14/2016.	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure openings through 1 of 14 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the corridor door set by Room 30.	K 0025	It is the policy of Miller's Merry Manor that smoke barriersshall be constructed to provide at least a one half hour fire resistance ratingand constructed in accordance with 8.3 Smoke barriers shall be permitted toterminate at an atrium wall. This deficient practice could affect 20 resident, staff, andvisitors in the vicinity of the corridor set by room 30. A tour of the facility sprinkler pipes was completed by themaintenance director on 4/26/2016 to ensure that no other sprinklers neededfilled with a material to maintain the fire resistance rating of the smokebarrier wall. This tour revealed no issues with any of the smoke barrier wallshaving holes. All The space	04/15/2016

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, the one inch annular space surrounding a three and one half inch in diameter sprinkler pipe which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by Room 30 was not filled with a material to maintain the fire resistance rating of the smoke barrier wall. Based on interview at the time of observation, the Maintenance Director acknowledged the opening in the aforementioned smoke barrier wall was not filled with a material to maintain the fire resistance rating of the smoke barrier wall. 3.1-19(b)		surroundinga three and one half inch diameter sprinkler pipe which penetrated the smokebarrier wall above the suspended ceiling above the corridor door set by room 30was filled with a material to maintain the fire resistance rating of the smokebarrier wall on 4/15/2016. This deficient practice was corrected on 4/15/2016.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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			

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	Based on observation and interview, the facility failed to ensure 1 of 12 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the Mechanical Room in Pioneer Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, two open ended conduits each measuring two inches in diameter penetrated the north wall of the Mechanical Room in Pioneer Hall near the ceiling and failed to separate this area from other areas by smoke resistant partitions. One conduit was for the passage of a one inch in diameter copper pipe and the second conduit was for the passage of a one inch in diameter water line. The north wall separated the Mechanical Room from the Medical Records Storage Room. The Mechanical Room in Pioneer Hall contained two natural gas fired water heaters. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the north wall of the Mechanical Room in Pioneer Hall did not separate this hazardous area	K 0029	Itis the policy of Miller's Merry Manor to ensure hazardous areas such as fuelfired heater rooms were separated from other areas by smoke resistantpartitions. This deficient practice could affect 12 residents, staff, andvisitors in the vicinity of the mechanical room in pioneer hall. The two openended conduits measuring two inches in diameter that penetrated the north wallof the mechanical room near the ceiling and failed to separate the mechanicalroom from the medical records storage room. The two areas have been filled inwith fire cocking. A tour of the facility was done by maintenance director on4/27/2016 and no other issues were found. This issue has been corrected as of4/15/2016.	04/15/2016

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	from other spaces by smoke resistant partitions. 3.1-19(b)			
K 0039 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation and interview, the facility failed to ensure 1 of 6 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Construction Manager during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, the exit access corridor by the Oxygen Storage Room provides one of three paths of egress from Harrison Hall. A wooden particle board wall was constructed in the corridor from floor to ceiling to block off a portion of Harrison Hall by Room 15 to keep residents and visitors from entering that portion of the corridor during renovation. The particle board wall was constructed in a pattern which projected into the corridor leaving	K 0039	It is the policy of Miller's Merry Manor that thewidth of aisles or corridors serving as exit access is at least 4 feet. Thisdeficient practice could affect all residents, staff, and visitors. The widthof the corridor serving as an exit that did not meet the 4 feet requirement wasfixed and is now meets the 4 feet width requirement. The construction team was educated on this regulationand aware that if any other temporary walls are built they need to be incompliance with this regulation. This deficient practice was corrected on4/25/2016.	04/25/2016

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	a 37 inch wide exit width in between the northwest corner of the constructed particle board wall and the wall for the exit access corridor by the Oxygen Storage Room. Based on interview at the time of the observations, the Construction Manager stated the particle board wall was constructed such that the south and east corridor handrails at the corner intersection of Harrison Hall and the Atrium Hallway by Room 15 could be blocked off and replaced during facility renovation. Based on interview at the time of the observations, the Maintenance Director acknowledged the exit access corridor by the Oxygen Storage Room did not have a clear an unobstructed width of at least 4 feet (48 inches) due to the construction of the particle board wall in Harrison Hall by Room 15. 3.1-19(b)			
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25,	K 0062	It is the policy of Miller's Merry Manor that allrequired automatic sprinkler systems are continuously maintained in reliableoperation condition and are inspected and	04/25/2016

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the Medical Records Storage Room in Pioneer Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, cardboard storage boxes were stacked on top of one another to within twelve inches of the ceiling which blocked the spray pattern of a ceiling mounted pendant sprinkler in the Medical Records Storage Room in Pioneer Hall. Based on interview at the time of observation, the Maintenance Director acknowledged the Medical Records Storage Room pendant sprinkler had obstructions to its discharge.		tested periodically. This deficientpractice could affect 12 residents, staff, and visitors in the vicinity of themedical records storage room in pioneer hall. The cardboard storage boxes thatwere found stacked within twelve inches of the ceiling which blocked the spraypattern of a ceiling mounted pendant sprinkler in the medical records storageroom in pioneer hall. The boxes were placed there that morning awaiting arrivalof a company to dispose of those records.. To prevent further occurrences ofthis deficient practice the business office manager whom stores the boxes inthat location was educated on not stacking boxes and ensuring that there is atleast 12 inches between the boxes and the ceiling. This was corrected on4/25/2016	

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	3.1-19(b)			
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to document inspection of 1 of 24 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect three residents, staff and visitors in the Beauty Shop. Findings include: Based on observation with the Maintenance Director during a tour of the	K 0064	It is the policy of Miller's Merry Manor that portablefire extinguishers shall be installed, inspected, and maintained in allhealthcare occupancies in accordance with 9.7.4.1, NFPA 10. The fireextinguisher found that had not been inspected within the monthly time wasinspected almost immediately and date of inspection applied to tag. To preventfuture occurrences the maintenance director or designee will complete the tool(Attachment B) monthly. Any identified issues will be corrected upon discoveryand logged n the facility QA tracking log. QA tracking logs are reviewed in thefacility monthly QA meeting to monitor ongoing compliance. All systematicchanges will be completed by 5/15/2016. All residents, staff, or visitors hadthe potential to be affected by this deficient practice.	05/15/2016

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	facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, the inspection tag affixed to the portable fire extinguisher in the Beauty Shop indicated a monthly inspection was not documented for March 2016. Based on interview at the time of observation, the Maintenance Director acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for March 2016. 3.1-19(b)			
K 0067 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers	K 0067	It is the policy of Miller's Merry Manor to ensureall fire dampers in the facility are inspected and provided necessarymaintenance at least every four years in accordance with the NFPA 90A. The firedamper that had the inspection date of 10/24/2016 was inspected on 10/24/2015and was misprinted by the inspector. Please see (Attachment C) a letter fromJohn Simmons stating when he inspected the fire damper and the correctdate. The date of inspection of10/24/2015 puts us in compliance with ensuring all fire dampers are inspectedand provided necessary maintenance at least every four	04/19/2016

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	shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Damper Inspection" documentation dated 10/24/16 with the Maintenance Director during record review from 9:50 a.m. to 12:10 p.m. on 04/14/16, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. The aforementioned documentation listed the future date of 10/24/16 as the necessary maintenance date for three of three fire dampers referenced in the aforementioned documentation. Based on observation with the Maintenance Director at 2:30 p.m. on 04/14/16, the fire damper above the suspended ceiling in the corridor by the Harrison Hall nurse's station had an affixed sticker stating the damper number only and no maintenance date. Based on interview at the time of record review and of the observation, the Maintenance Director stated no other documentation was available for review to refute the inspection date of 10/24/16 on the		years accordance withthe NFPA 90A. The date has been corrected on the damper inspection as well.	

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
	155564		04/14/2016

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	aforementioned documentation and acknowledged fire damper inspection and maintenance documentation within the most recent four year period for all facility fire dampers was not available for review. 3.1-19(b)			
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 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 1 of 8 exits means of egress. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on an initial walk through of the facility at 9:40 a.m. on 04/14/16 with the Administrator and the Maintenance Director, a plastic three drawer chest of drawers containing isolation equipment was stored in the Pioneer Hall corridor outside Room 47 and Room 49. Based	K 0072	It is the policy of Miller's Merry Manor that meansof egress shall be continuously maintained and free of all obstruction or impedimentsto full instant use in the case of fire or other emergency. No furnishings,decorations, or other objects shall obstruct exits, access thereto, egressthere from, or visibility thereof shall be in accordance with 7.1.10 18.2.1,and 19.2.1.This deficient practice could affect 10 residents, staff, andvisitors. On 4/25/2016 over the door isolation storage caddies were order tocorrect this deficient practice (Attachment D). These caddies for isolationequipment will be in place no later than 5/15/2016. Nursing staff were educatedon 4/22/2016	05/14/2016

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	on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, the aforementioned two plastic chest of drawers containing isolation equipment was continued to be stored in the Pioneer Hall corridor outside Room 47 and Room 49. Each of the chest of drawers projected twelve inches into the corridor. Based on interview at the time of the observations, the Maintenance Director stated staff needed isolation equipment storage for the residents in Room 47 and Room 49 and acknowledged corridor storage in the means of egress for the Pioneer Hall corridor was not continuously maintained free of all obstructions or impediments to full instant use. 3.1-19(b)		about the new caddies and that the isolation bins cannot be storedin the hallways. The audit tool (Attachment E) will be completed by theadministrator or designee weekly for four weeks and then monthly thereafter tomonitor for compliance. Any identified issues will be corrected upon discoveryand logged on the facility QA tracking log. QA tracking logs are reviewed inthe facility QA meeting to monitor ongoing compliance. All systematic changeswill be completed by 5/14/2016.	
K 0130 SS=C Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring	K 0130	It is the policy of Miller's Merry Manor to ensure fuelfired water heaters have current inspection certificates to ensure fuel firedwater heaters have current inspection certificates to ensure the water heatersare in safe operating condition. We had the water heaters inspected March of2015 but for some reason the invoice was not paid so we did not receive theactual	04/25/2016

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	the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 2:15 p.m. on 04/14/16, the following five water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana: a. the service water heater identified as IN308054 had a Certificate of Inspection posted at the unit stating the expiration date was 02/07/15. b. the service water heater identified as IN247162 had a Certificate of Inspection posted at the unit stating the expiration date was 02/07/15. c. the service water heater identified as IN310494 had a Certificate of Inspection posted at the unit stating the expiration date was 02/07/15. d. the service water heater identified as IN308053 had a Certificate of Inspection posted at the unit stating the expiration date was 02/07/15. Based on interview at the time of the observations, the Maintenance Director stated documentation of current Certificate of Inspection documentation is kept in no other location than at the		certificates. Since our survey we have paid the invoice and allcertificates are current and up to date (Attachment I). This deficient practiceaffects all residents, staff and visitors. To correct this from happening inthe future the maintenance director changed who the invoice is addressed to soit will get to the right person. The active certificates were placed on 4/25/2016.	

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	service water heater locations and acknowledged the aforementioned service water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana. 3.1-19(b)			