

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155581	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/26/12</p> <p>Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450</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)</p>	K0000	Please accept the enclosed plan of correction as credible allegation of compliance to the deficiencies cited during our annual Life Safety Code Survey conducted on September 26, 2012, at Millers Merry Manor in Syracuse.	

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>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 66 and had a census of 46 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/04/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 resident room corridor doors in the Teal Pod closed and latched into the door frame. This deficient practice could affect any of the 10 residents in the Teal Pod.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 12:18 p.m., the corridor door to resident room 301 would not be latch into the door frame on the first two attempts. The Maintenance</p>	K0018	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K018. All residents have the potential to be affected by this practice. The door entering Resident Room 301 has been adjusted to close on October 5, 2012. Maintenance Supervisor or designee will monitor 10 rooms per week for 3 months and then 10 rooms monthly after that (Attachment A Life Safety Code room and fire door review). Results will be reviewed by Administrator weekly and with the QA committee monthly. All changes will be completed by 10-26-12.</p>	10/26/2012			

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	<p>Supervisor had to physically pull and slam the door before it could be latched. Based on an interview with the Maintenance Supervisor at the time of observation, the door was rubbing on the door frame and it needed to be shaved off.</p> <p>3.1-19(b)</p>			

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K0025 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 maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 16 residents in the Lakeshore Pod.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 12:46 p.m., there is a two and one half inch by two and one half inch hole in the ceiling beside the sprinkler head in the bathroom of resident room 207 exposing the bathroom to the</p>	K0025	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K025. All residents have the potential to be affected by this practice. The two and one half inch hole in room 207 was repaired on 10-4-2012. To ensure that there are no holes in the ceiling of the facility resident rooms will be monitored by Maintenance Supervisor 10 rooms per week for 3 month and then 10 rooms monthly after that (Attachment A). Results of this audit will be reviewed by the Administrator weekly and the QA committee monthly with all deficiencies being fixed immediately. All changes will be completed by 10-26-12.</p>	10/26/2012	

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	attic. Based on an interview with the Maintenance Supervisor at the time of observation, the sprinkler head had been closer than four inches from the the wall and was moved by SafeCare.  3.1-19(b)				

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 16 residents in the Teal Pod and the main dining room with a capacity of 52 residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 from 12:29 p.m. to 1:29 p.m., the south door of the</p>	K0044	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K044. All residents have the potential to be affected by this practice. The deficient fire doors off the main dining room and the doors set entering Teal Pod have been adjusted to close by Maintenance Supervisor on 10-10-12. All fire doors will be monitored by Maintenance Supervisor or designee weekly (Attachment A). The results of his audits will be discussed weekly with Administrator and monthly by QA committee with all deficiencies being fixed immediately. All changes will be completed by 10-26-12.</p>	10/26/2012	

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	<p>fire door set entering the Teal Pod failed to latch into the frame. Additionally, the north door on the fire door set entering the main dining room failed to latch into the frame. This was acknowledged by the Maintenance Supervisor and the Administrator at the time of observations and the Maintenance Supervisor confirmed these doors were fire doors.</p> <p>3.1-19(b)</p>				

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K0062 SS=C	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure the spray pattern for 12 of 12 sprinkler heads in the sky lights and 1 of 2 sprinkler heads in the clean side of the laundry room were unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained 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 46 residents.</p> <p>Findings include:</p> <p>a. Based on observations with the Administrator and the Maintenance Supervisor on 09/26/12 at 11:55 a.m. to 1:44 p.m., each pod has four ceiling sky lights in the center lounge</p>	K0062	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K062. All residents have the potential to be affected by this practice. The curtains that were restricting the flow of the sprinkler heads in the skylights have been taken down.</p> <p>The sprinkler head in the Laundry Room will be moved by Safe Care to the correct distance away from the light. The sprinkler heads will be monitored by Maintenance Supervisor or designee weekly for 8 weeks then Quarterly there after (Attachment B Life Safety Code Review). Results will be discussed by QA committee monthly. The backflow preventers is being rebuilt and put back in compliance by Safe Care. The Annual inspection is being put on a schedule by our Maintenance Supervisor with Safe Care. This will be inspected a month before the expiration date. All deficiencies will be corrected by 10-26-2012.</p>	10/26/2012	

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	<p>area. A curtain has been installed in each sky light to prevent the direct sunlight from shining into the lounge area. The curtain in each sky light is suspended below the sprinkler head. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>b. Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 1:25 p.m., the sprinkler head above the dryers was located three inches from a ceiling light fixture. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to annually test the backflow preventers for 1 of 1 sprinkler systems required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 9-6.2.1 which states all backflow preventers installed in fire protection system piping shall</p>						

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	<p>be tested annually. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 1:21 p.m., there were two backflow prevention assembly devices on the sprinkler system. Based on an interview with the Maintenance Supervisor at the time of observation, the backflow devices have not been inspected and he could not provide documentation of an inspection report.</p> <p>3.1-19(b)</p>				

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K0069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice was not in a resident area but could affect staff.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and the Maintenance Supervisor on 09/26/12 at 11:17 a.m., the 360 Degree Services kitchen hood cleaning report titled "Service Report" dated 09/12/12 stated "Main hood fan bowl damaged upon arrival. Dish hood fan is nailed to ductwork could not remove. Both fans need hinge kits. Main hood fan has a wiring</p>	K0069	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K062. All residents have the potential to be affected by this practice. The hinge kits will be installed on both fans. The wiring deficiency will be also being corrected. All services will be completed by 360 Degree Services. To insure deficiencies are corrected Maintenance Supervisor or designee will inspect hood monthly for 3 months then quarterly there after (Attachment B). Results of the inspection will be reviewed by QA committee monthly. All deficiencies will be corrected by 10-26-12.</p>	10/26/2012			

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	<p>deficiency." Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available to show these deficiencies have been corrected.</p> <p>3.1-19(b)</p>				

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors at the opening in the kitchen wall, a hazardous area, was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect as many as 52 residents in the main dining room.</p>	K0130	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K130. All residents have the potential to be affected by this practice. The annual inspection of the rolling fire door was completed on 10-2-12 by Overhead Door Company to put this back into compliance. This inspection should be completed annually and will be placed on a Schedule to be inspected a month before the expiration date. All deficiencies will be corrected by 10-26-12.</p>	10/26/2012

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	<p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 11:10 a.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on the Overhead Door inspection form the last annual inspection was conducted on 05/26/11. Based on interview with the Maintenance Supervisor at the time of observation, no other documentation was available for review.</p> <p>3.1-19(b)</p>				

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 provided with continuous mechanical ventilation. This deficient practice could affect residents evacuated through the back core nurses' station exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 09/26/12 at 1:15 p.m., the oxygen transfilling/storage room</p>	K0143	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K143. All residents have the potential to be affected by this practice. The Mechanical Vent has been replaced by Maintenance Supervisor 10-3-12. To prevent this deficient practice the Maintenance Supervisor or designee will monitor the Mechanical Vent weekly for 8 weeks then monthly there after (Attachment B ). The results of the audits will reviewed by QA Committee monthly. All deficiencies will be corrected by 10-26-12.</p>	10/26/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155581	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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	<p>contained four large cylinders of liquid oxygen and the mechanical vent could not be heard. Based on an interview with the Maintenance Supervisor at the time of observation, the mechanical ventilation was not working.</p> <p>3.1-19(b)</p>			

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567		
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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects 46 residents.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Emergency Generator Underload Exercise" with the Administrator and the Maintenance Supervisor on 09/26/12 at 11:33 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly</p>	K0144	<p>The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K144. All residents have the potential to be affected by this practice. The transfer times will be logged on (Attachment C) monthly to maintain compliance. This will be monitored monthly by Maintenance Supervisor and reviewed by Administrator monthly for 3 months then quarterly. The results of the audit will be reviewed by QA committee monthly. All deficiencies will be corrected by 10-26-12.</p>	10/26/2012	

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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567		
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	<p>load test record did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				