

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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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: 11/20/14</p> <p>Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140</p> <p>Surveyor: Mark Bugni, 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000		
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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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K010025 SS=F	<p>has a capacity of 60 and had a census of 35 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached wooden storage building which was not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/09/14.</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 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 observations and interview, the facility failed to ensure 3 of 5 attic smoke barrier walls were constructed to provide</p>	K010025	Plan of Correction for Middletown 2567 11.20.14	12/29/2014	

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	<p>at least a one half hour fire resistance rating. This deficient practice affects 11 residents who reside on the East Hall, 19 residents who reside on the West Hall and 5 residents who reside on the North Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 11/20/14 from 1:00 p.m. to 1:40 p.m., the following attic smoke barrier walls had penetrations not fire stopped or missing drywall;</p> <p>a. The East Hall smoke barrier wall had a one inch gap around a sprinkler pipe penetration and a two inch gap around a cable bundle penetration not fire stopped.</p> <p>b. The West Hall smoke barrier wall had four, two inch gaps around water pipe and duct penetrations not fire stopped.</p> <p>c. The North Hall smoke barrier wall had two, two inch gaps around water pipe penetrations not fire stopped. The East Hall, West Hall, and North Hall attic smoke barriers penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the Administrator at the exit conference on 11/20/14 at 2:00 p.m.</p> <p>3.1-19(b)</p>		<p>We respectfully request paper compliance for this plan of correction. All of the attachments to indicate we are meeting the requirements of 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 are attached in our Plan of Correction. Please contact Michelle Watkins, H.F.A., Miller's Merry Manor of Middletown, 765-354-2278 if there is a need for any more information.</p> <p>K025</p> <p>It is the policy of Miller's Health Systems, Inc. to not exceed 1/8 smoke barrier gap.</p> <p>This deficient practice could have potentially affected 11 residents who reside on the east hall, 19 residents who reside on the West hall, and 5 residents who reside on the North Hall.</p> <p>The following measures have been implemented to ensure the deficient practice does not recur. The Maintenance Director was inserviced by the administrator on 12/1/14.regarding Miller's Policy and Procedure for the smoke barriers in the facility to not exceed 1/8. (Attachment A). The facility's Maintenance Director will use the QA tool titled "Life Safety Review" to ensure all smoke barriers have the proper gap (Attachment B).</p> <p>To ensure this deficient practice</p>	

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K010067 SS=F	<p>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</p> <p>Based on observations and interview, the facility failed to ensure portable space heaters were prohibited in areas used by residents. LSC 19.5.2.2 requires any heating device other than a central heating plant shall be designed and installed so that combustible material shall not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustion system from the atmosphere</p>	K010067	<p>does not recur, the facility's Maintenance Director will use the QA "Life Safety Review" one a month for 3 months and then quarterly thereafter (Attachment B). The QA committee will review and make recommendations as necessary.</p> <p>The gap on the smoke barriers was minimized with some additional concrete and intumescent fire caulk on 12/17/14. Systematic changes will be completed by 12/29/14.</p> <p>Plan of Correction for Middletown 2567 11.20.14</p> <p>We respectfully request paper compliance for this plan of correction. All of the attachments to indicate we are meeting the requirements of 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 are attached in our Plan of Correction. Please contact Michelle Watkins, H.F.A., Miller's Merry Manor of Middletown, 765-354-2278 if there is a need for any more information.</p> <p>K067</p>	12/29/2014

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	<p>of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p> <p>Exception # 1states, Approved, suspended unit heaters shall be permitted in locations other than means of egress and patient sleeping areas, provided that such heaters are located high enough to be out of the reach of persons using the area and are equipped with the safety features required by 19.5.2.2. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the East Hall shower room and beauty shop on 11/20/14 at 12:45 p.m. with the maintenance supervisor, each room had a portable electric space heater mounted on a metal bracket from the ceiling. Furthermore, each heater was mounted five feet three inches from the floor near the door. Based on an interview with the maintenance supervisor on 11/20/14 at 12:55 p.m., the space heaters do not have any safety features such as an automatic shut off when they overheat and are manual space heaters with a manual temperature adjustment switch. The use of portable space heaters in resident areas</p>		<p>It is the policy of Miller's Health Systems, Inc. to prohibit portable space heaters within all MHS buildings.</p> <p>This deficient practice could have potentially affected all residents who use the shower room and/or the beauty shop.</p> <p>The following measures have been implemented to ensure the deficient practice does not recur. The Maintenance Director was inserviced by the administrator on 12/1/14.regarding Miller's Policy and Procedure for the identification of space heaters in the facility. (Attachment C). The facility's Maintenance Director will use the QA tool titled "Maintenance Services Review" to ensure all equipment is safe and functioning properly (Attachment D).</p> <p>To ensure this deficient practice does not recur, the facility's Maintenance Director will use the QA "Maintenance Services Review" one a month (Attachment D). The QA committee will review and make recommendations as necessary.</p> <p>The portable space heaters were removed on 12/1/14 and systematic changes will be completed by 12/29/14.</p>	

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	without safety features to immediately shut down the devices and the space heaters mounted from the ceiling near the doors at a height making residents susceptible to burning was verified by the maintenance supervisor and administrator at the time of observation and interview. 3.1-19(b)				