

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/22/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH ST LOGANSFORT, IN 46947 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| 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: 07/2214</p> <p>Facility Number: 000140 Provider Number: 155235 AIM Number: 100266960</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor was found in substantial 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 three story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident</p> | K010000 | <p>Please accept the attached plan of correction as credible allegation of compliance to the deficiency cited during our Annual Life Safety Code Survey conducted on July 22, 2014. Hopefully, you will find the remedy sufficient, thoroughly explained, and able to provide a clear picture of how we corrected the concern. I would like to formally request your consideration for granting this facility paper compliance. If after reviewing our plan of correction you have any questions or require additional information, please contact me at 574-722-4006</p> | |

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.

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/22/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH ST LOGANSPORT, IN 46947 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| K010052 SS=C | <p>rooms. The facility has a capacity of 127 and had a census of 112 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the one detached brick garage and a maintenance building which are used to store maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/24/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> | | | |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/22/2014 | |
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH ST LOGANSPORT, IN 46947 | | | |
| (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 | | | |
| | <p>Based on observation and interview, the facility failed to ensure 1 of 12 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, accessible, and located in the path of exit from the area. This deficient practice could affect all residents as well as visitors and staff if there was a delay in notifying staff of a fire emergency on north wing.</p> <p>Findings include:</p> <p>Based on observation on 07/22/14 at 12:45 p.m. with the Maintenance Supervisor, the manual fire alarm box # 6 provided for the north exit on first floor was located in the stairwell exit foyer which was only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants. Based on interview on 07/22/14 at 12:47 p.m. with the Maintenance Supervisor it was acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.</p> | K010052 | <p>The facility respectfully submits the following plan of correction as credible allegation of compliance.I. To correct the deficient practice the manual fire alarm box is being moved to the opposite side of the door as to avoid obstruction by the use of a keypad override code. The work is scheduled to take place on 8/4/14 (Attachment #1).II. All residents have the potential to be affected by this deficient practice.III. To ensure the deficient practice does not recur and audit was completed for all other maunal fire alarm boxes with no obstructions noted.IV. The corrective action does not require continued monitoring as all other manual fire alarm pulls have been audited and no obstructions are noted.V. The corrections will be completed by 8/5/14.</p> | 08/04/2014 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155235 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/22/2014 |
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH ST LOGANSPORT, IN 46947 | | |
| (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 | |
| | 3.1-19(b) | | | | |