

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  04/26/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1651 N CAMPBELL ST INDIANAPOLIS, IN 46218
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K0000	<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: 04/26/12</p> <p>Facility Number: 000500 Provider Number: 155557 AIM Number: 100266220</p> <p>Surveyor: Mark Caraher, 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 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 all areas open to the corridor. The facility</p>	K0000		

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>has battery operated smoke detectors in all 60 resident rooms. The facility has a capacity of 114 and had a census of 73 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/02/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a sprinkler head was installed in 1 of 1 elevator rooms to provide coverage for all portions of the building. NFPA 13 at 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. This deficient practice could affect residents, staff and visitors in the vicinity of the Elevator Machine Room near the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, the Elevator Machine Room near the Main Dining Room did not have a sprinkler head installed. Based</p>	K0056	<p>K056</p> <p>Please accept the following plan of correction for the deficiency cited under tag K056. This deficient practice could affect residents, staff and visitors in the vicinity of the Elevator Machine Room near the Main Dining Room.</p> <p>To correct this deficient practice a sprinkler head is being installed in the Elevator Room. This sprinkler head will be installed and meet code by May 26 th , 2012.</p>	05/26/2012			

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	<p>on interview at the time of observation, the Maintenance Supervisor acknowledged the Elevator Machine Room near the Main Dining Room did not have a sprinkler head in the room.</p> <p>3.1-19(b)</p>			

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 2 outside areas where smoking was permitted. This deficient practice could affect any resident, staff and visitors in the vicinity of the outside gazebo smoking area by the exit next to Room 227.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0066	<p>K066 Please accept the following plan of correction for the deficiency cited under tag K066. This deficient practice could affect residents, staff and visitors in the vicinity of the outdoor courtyard... To correct this deficient practice an ashtray of noncombustible material and safe design is provided in all areas where smoking is permitted. This deficiency was immediately corrected... To prevent reoccurrence the Maintenance staff will make sure the ashtrays are emptied and in</p>	05/26/2012			

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	<p>Maintenance Supervisor during the tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, the gazebo smoking area twenty feet outside of the building by the exit next to Room 227 had two uncovered noncombustible ash trays with twenty or more extinguished cigarette butts in each ash tray. The gazebo smoking area had one plastic trash can lined with a plastic trash bag which had combustible waste paper and twenty cigarette butts disposed of in the trash can. Based on interview at the time of observation, the Maintenance Supervisor acknowledged cigarette butts from the uncovered ash trays had been disposed of into a plastic container lined with a trash bag.</p> <p>3.1-19(b)</p>		good working order on their daily rounds.		

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K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 utility rooms containing natural gas fired water heaters was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could affect any resident, staff and visitors in the vicinity of the South Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, the South Mechanical Room which contains one natural gas fired water heater is not provided with intake combustion air from the outside. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there is no intake combustion air from the outside supplied to the South Mechanical Room for the natural gas fired water heater.</p> <p>3.1-19(b)</p>	K0068	<p>K068 Please accept the following plan of correction for the deficiency cited under tag K068. This deficient practice could affect residents, staff and visitors in the vicinity of the South Mechanical Room. To correct this deficient practice a ventilation line was installed into the mechanical room.</p>	05/26/2012

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K0130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system 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 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, the rolling fire door</p>	K0130	<p>K130</p> <p>1. Please accept the following plan of correction for the deficiency cited under tag K130. This deficient practice could affect residents, staff and visitors in the vicinity of the Dining Room. To correct this deficient practice Safe care our fire protection service vendor inspected the rolling door on 4-27-12. To prevent reoccurrence of this deficient practice the Maintenance Director will be checking for compliance through the annual inspection process. The proper inspection tags will be initialed and service records kept ensuring the proper compliance.</p> <p>2. Please accept the following plan of correction for the deficiency cited under tag K130. This deficient practice could affect residents, staff and visitors in the vicinity of the second floor. The deficiency was immediately corrected by installing a latch on the attic fire barrier door on the second floor</p>	05/26/2012			

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	<p>protecting the opening from the kitchen to the Main Dining Room had an inspection tag indicating the most recent annual inspection of the rolling fire door was performed on 03/22/11. The Main Dining Room is open to the corridor, thus the rolling fire door is in a corridor wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged it has been more than one year since the most recent annual inspection of the rolling fire door to check for proper operation and full closure was performed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 access doors in an attic fire barrier wall closes and latches to provide the protection needed for a two hour fire barrier. LSC 7.2.4.3.4 requires any opening in fire barriers be protected as provided in 8.2.3. LSC 8.2.3.2.1 requires fire doors to be installed in accordance with NFPA 80, Standard for Fire Doors and Windows. NFPA 80 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 residents, staff and visitors in the vicinity of the</p>			

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	<p>attic access door in the fire barrier wall near the second floor stairwell landing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, the attic access door in the fire barrier wall near the second floor stairwell landing is not equipped with a positive latching mechanism. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the attic access door in the fire barrier wall near the second floor stairwell landing is not equipped with a positive latching mechanism.</p> <p>3.1-19(b)</p>				

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident, staff or visitor in the vicinity of the Memory Care Facilitator's office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during the tour of the facility from 12:00 p.m. to 2:15 p.m. on 04/26/12, a refrigerator and a microwave oven were plugged into a power strip in the second floor break room and a refrigerator was plugged into a power strip in the second floor Maintenance Office. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged refrigerators and a microwave oven were plugged into a power strip in the aforementioned locations.</p> <p>3.1-19(b)</p>	K0147	<p>K147 . Please accept the following plan of correction for the deficiency cited under tag K147. This deficient practice could affect residents, staff and visitors in the vicinity of the second floor. To correct this deficient practice the surge protector was immediately removed. An additional out let was then installed.</p>	05/26/2012			

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