

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573
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K 0000 Bldg. 01	<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: 09/08/15</p> <p>Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980</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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. 73 resident rooms were provided with battery operated smoke detectors. The facility has a capacity of 133 and had a census of 118 at the time</p>	K 0000		

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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K 0011 SS=E Bldg. 01	<p>of this survey.</p> <p>Quality Review completed on 09/11/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to nonconforming buildings was protected by a two hour fire rating. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Support Services and Assistant Maintenance #1 on 09/08/15 at 12:47 p.m., the firewall which separates the health care building from assisted living building, a nonconforming building, had a 20 minute fire rated door. Based on Interview at the time of observation, the Director of Support Services and Assistant Maintenance #1 acknowledged the 20 minute rating on the separating door, and was unable to confirm the</p>	K 0011	<p>We respectfully request an IDR for this deficiency. This deficiency is in dispute as we attempt to clarify whether or not the common fire wall between the SNF & the non-conforming building (assisted living facility) has a fire rating of 2 hours, or not. We currently have an engineer researching this issue to verify the exact fire rating for this common wall as we have been unable to obtain the original blueprints for the common wall in question up to this point in time.</p>	10/08/2015			

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K 0025 SS=D Bldg. 01	<p>construction of a two hour wall separating the nonconforming building.</p> <p>3.1-19(b)</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 observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed</p>	K 0025	<p>No residents were directly affected by this deficiency. Any resident located near the Social Services Director's office could have had the potential to be affected by this deficiency. Fire caulk was added to seal off the penetrated area near the Social Services Director's office on 9/10/15. The Maintenance Supervisor, or designee, will complete a "Fire Wall Penetration Check" (Attachment A) on a quarterly basis to check for any areas with fire wall penetrations. Any findings will be repaired immediately & will be reviewed at the monthly facility Quality Assurance meeting ongoing to ensure future compliance.</p>	09/10/2015

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K 0130 SS=D Bldg. 01	<p>for the specific purpose. This deficient practice could affect two of nine smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Director of Support Services and Assistant Maintenance #1 on 09/08/15 at 1:49 p.m. the smoke barrier wall near the Social Service Director's office had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a 3/8" hole to allow phone cables to pass through. Based on interview at the time of observation, the Director of Support Services and Assistant Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 Mechanical Room in Maintenance Hall water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency</p>	K 0130	No residents were directly affected by this deficiency. Any residents located near the Mechanical Room in the Maintenance Hall could have had the potential to be affected by this deficiency. A State Inspector was present on 5/17/15 & inspected the water heater in the Mechanical Room & affixed a sticker on the water	09/09/2015

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K 0147 SS=D Bldg. 01	<p>requiring the evacuation of residents. This deficient practice could affect residents near the Maintenance Hall.</p> <p>Findings include:</p> <p>Based on record review and interview on 09/08/15 at 12:14 p.m., the Director of Support Services and Assistant Maintenance #1 acknowledged one of two mechanical room water heaters had a Certificate of Inspection that expired on 05/30/15.</p> <p>3.1-19(b)</p> <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 12 of 12 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless</p>	K 0147	<p>heater indicating that this piece of equipment was in proper working order. We then applied & were waiting for the Certificate of Inspection to arrive from the Department of Homeland Security after the Inspector visited us on 5/17/15. We found a copy of the Certificate of Inspection in the Maintenance Director's mail box on 9/9/15 & we installed it in a prominent location near the water heater on 9/9/15. It is unfortunate that we were unable to obtain the Certificate of Inspection sooner between when the original inspection occurred on 5/17/15 & when the Life Safety Code inspection occurred on 9/8/15 as the delay with obtaining the Certificate of Inspection from the Department of Homeland Security contributed to this deficiency being cited. Our water heater was in proper working order during the time we were waiting to obtain the Certificate of Inspection.</p> <p>No residents were directly affected by this deficiency. Any residents located near the areas where the surge protectors were in use could have had the potential to be affected by this deficiency. All surge protectors & multiplug devices have been removed facility-wide. A letter will</p>	10/08/2015	

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	<p>specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 33 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Support Services and Assistant Maintenance #1 on 09/08/15 between 11:26 a.m. to 1:17 p.m. the following was discovered:</p> <ul style="list-style-type: none"> a) a surge protector was powering a refrigerator in the Executive Director's office b) a multiplug was powering an oxygen concentrator in resident room 102 c) a surge protector was powering a refrigerator in resident room 109 d) a surge protector was powering a refrigerator in resident room 110 e) a surge protector was powering an oxygen concentrator in resident room 111 f) a surge protector was powering a refrigerator in resident room 116 g) a surge protector was powering a refrigerator in the Office Manager office h) a surge protector was powering another surge protector powering computer components in the Sunshine exit hall i) a surge protector was powering a refrigerator in resident room 8 		<p>be sent to all residents, families/responsible parties by the first week of October to explain the importance of not bringing surge protectors or multiplugs into the facility for use in resident rooms, etc. Facility Staff were inserviced on 9/10/15 (Attachment B), & another inservice will be given on 10/1/15, regarding not using surge protectors & multiplug devices in the facility. The Maintenance Supervisor, or designee, will complete an "Electrical, GFI & Powerstrip Checklist" (Attachment C) on a quarterly basis to make sure that no surge protectors or multiplug devices are present in the facility. Any findings will be corrected immediately & will be reviewed at the monthly facility Quality Assurance meeting ongoing to ensure future compliance with this deficiency.</p>	

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	<p>j) a surge protector was powering an oxygen concentrator in resident room 2</p> <p>k) a surge protector was powering a refrigerator in the Assistant Director of Nursing office.</p> <p>Based on interview at the time of observation, the Director of Support Services and Assistant Maintenance #1 acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>				