

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 07/08/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 200 26TH ST LOGANSPORT, IN 46947
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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: 07/08/13</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 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 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, spaces open to the corridors, and battery operated smoke detectors in all resident rooms.</p>	K010000	<p>Please accept the attached plan of correction as a credible allegation of compliance to the deficiencies cited during our annual Life Safety Certification Survey conducted on 7/8/13 at Miller's Merry Manor in Logansport. I would like to formally request your consideration for granting this facility paper compliance.</p>	
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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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	<p>The facility has a capacity of 127 and had a census of 106 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 which is used to store maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010062 SS=F	<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>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect all residents in the facility as well as visitors and staff should the sprinkler pipe break and require repair.</p> <p>Findings include:</p> <p>Based on observation on 07/08/13 at 2:45 p.m. with the Maintenance Supervisor, a ten foot section of a one and one half inch diameter sprinkler pipe was used to support copper plumbing from the # 2 boiler in the basement. Based on interview on 07/08/13 at 2:48 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler pipe was used to support copper plumbing from the # 2 boiler in the basement.</p>	K010062	<p>K062 NFPA 101 Life Safety Code Standard The facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K062. I. To correct the deficient practice the supporting mechanisms for the copper plumbing from the #2 boiler were relocated to the ceiling. The sprinkler pipe is no longer used for supporting the copper plumbing from boiler #2. II. All residents have the potential to be affected by this deficient practice. III. To ensure the deficient practice does not recur, the remaining areas of the basement were inspected by the maintenance staff to ensure no other sprinkler pipes were being used to support other piping. IV. The corrective actions will be monitored by the Maintenance Supervisor or his designee to ensure the deficient practice will not recur via monthly preventive maintenance checks. V. These corrective actions were completed by 9/7/13.</p>	08/07/2013			

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	3.1-19(b)				

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; 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 6 residents present in the Dining room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/08/13 at 1:45 p.m. with the Maintenance Supervisor, there was a rolling fire door protecting the</p>	K010130	<p>K130 NFPA 101 Life Safety Code Standard The facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K130. I. To correct the deficient practice the annual inspection was completed for the rolling fire door by SafeCare Incorporated (Attachment #1). The inspection tag was updated. II. All residents have the potential to be affected by this deficient practice. III. To ensure the deficient practice does not recur, the annual rolling fire door inspection will be added to the preventive maintenance tracking system. IV. The corrective actions will be monitored by the Maintenance Supervisor or his designee to ensure the deficient practice will not recur via monitoring of the preventive maintenance tracking system. V. These corrective actions were completed by 9/7/13.</p>	08/07/2013	

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	<p>opening from the kitchen to the Dining room with an attached inspection tag dated 2010. The Dining room was not open to the corridor. Based on interview on 07/08/13 at 1:47 p.m. and subsequent Fire Safety record review at 3:08 p.m. with the Maintenance Supervisor, it was acknowledged there was no additional documentation of an annual inspection or test to check for proper operation and full closure of the vertical rolling metal fire door.</p> <p>3.1-19(b)</p>			