

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155150	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2012
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NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 640 W ELLSWORTH ST COLUMBIA CITY, IN 46725
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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: 02/07/12</p> <p>Facility Number: 000071 Provider Number: 155150 AIM Number: 100273140</p> <p>Surveyor: Amy Kelley, 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 two story facility was determined to be of Type II (222) construction and was fully</p>	K0000		
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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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 84 and had a census of 57 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/12.</p>			
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K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5						
	Based on observation and interview, the facility failed to ensure 1 of 1 Sun Porches was separated from the corridor by a partition capable of resisting the passage of smoke, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to	K0017	<b>K017.</b> On 2/16/12, the facility's contracted provider of fire alarm system services installed an electrically supervised automatic smoke detector in the Sun Porch area. An additional electrically supervised automatic smoke detector was installed in the facility's Conference Room (Please See Attachment M-1). Both automatic smoke detectors were tied into the facility's fire alarm panel and are functioning properly. It will be the responsibility of the Environmental Services Director and Maintenance Technician to ensure that these two (2) new smoke detectors are added to the inventory of the existing smoke detectors and that they are tested as required by code. Completion Date was 2/16/12.  The facility submits this information as credible	02/16/2012			

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	<p>required exits. This deficient practice could affect any residents in the Sun Porch.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Assistant on 02/07/12 at 2:00 p.m., both corridor doors to the Sun Porch were chained in the open position. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the Sun Porch was not protected by an electrically supervised automatic smoke detection system. Based on an interview with the Administrator at the time of observation, he stated the local fire department wanted the doors held open by means other than a staff member during an emergency evacuation.</p> <p>3.1-19(b)</p>		allegations of compliance.		

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K0018 SS=E	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 remote serving kitchen corridor doors would close and latch into the door frame. This deficient practice could affect any resident near the serving kitchen in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Assistant on 02/07/12 at 2:05 p.m., the corridor door to the serving kitchen was a pocket door that did not latch into the frame. This was acknowledged by the Maintenance Assistant at the time of</p>	K0018	<p><b>K018.</b> On or before 3/8/12, the facility will be installing a ninety (90) minute fire rated metal door and door frame to the entrance of the serving kitchen. Further, a door closer will be installed to ensure that the door closes and latches into the frame when not in use. When the door is open for meal service, the door will be held open by an electromagnetic door release that will be tied into the facility's fire alarm system. Should the facility's fire alarm system be activated and the door to the serving kitchen is open, it will automatically close and latch into the door frame. This door will be checked during the facility's monthly fire drills to ensure that it closes and latches properly. If it is found not to close and latch properly, repairs will be made at that time. It will be the responsibility of the Environmental Services Director</p>	03/08/2012			

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	observations.  3.1-19(b)		or the Maintenance Technician to inspect all fire doors according to the Fire Door: Monthly Inspection Report (Please See Attachment M-2) to ensure that they are in proper working condition. Completion Date will be by 3/8/12. The facility submits this information as credible allegations of compliance.		

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K0056 SS=E	<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 1 of 1 sprinkler heads installed in the Therapy room supply closet was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice could affect any resident in the Therapy room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Assistant on 02/07/12 at 2:50 p.m., the sprinkler head in the Therapy room supply closet was mounted</p>	K0056	<p><b>K056.</b> On 2/16/12, the facility's contracted provider of sprinkler system services relocated the sprinkler head in the Therapy Room Supply Closet (Please See Attachment M-3). The sprinkler head is now approximately twenty-five and one-half inches (25 ½) from the wall. The sprinkler system service's technician, the facility's Maintenance Technician, and the facility's Administrator all confirmed that the sprinkler head was installed correctly and that no leaks in the pipe were noted. It will be the responsibility of the Environmental Services Director and Maintenance Technician to ensure that any new sprinkler heads that are installed are placed in accordance with the NFPA regulations. Completion Date was 2/16/12. The facility submits this information as credible allegations of compliance.</p>	02/16/2012			

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	<p>two inches from the wall. Measurements were provided by the Maintenance Assistant at the time of observation.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  Based on record review and interview, the facility failed to ensure the load testing for 5 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period	K0144	<b>K144.</b> On 2/15/12, the facility's contracted provider for generator services conducted a load test on the generator. During the test, the one (1) hour time frame showed a percent-of-load of seventy-five percent (75%) and the three (3) hour time frame showed a percent-of-load of thirty-eight percent (38%). This information is found on the "Generator Set Test Log" (Please See Attachment M-4). The facility will continue to conduct monthly load testing of the generator to ensure that is functioning under operating temperature conditions, minimum exhaust gas temperatures, or not less than thirty (30) percent of the nameplate rating for the diesel powered emergency generator set. The generator will be tested under load for at least thirty (30) minutes monthly. It will be the responsibility of the Environmental Services Director or Maintenance Technician to maintain a written record of the inspection, performance, exercising period, and repairs on the generator. This will be documented on the Emergency Generator: Monthly Load Test Form (Please See Attachment M-5-A and M-5-B). Completion Date was 2/15/12. The facility submits this information as	02/15/2012			

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	<p>and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the TELS program generator log titled "Monthly Load Test" with the Administrator and the Maintenance Assistant on 02/07/12 at 12:48 p.m., the generator test log showed a monthly load test for the past twelve months for a thirty minute duration but was operated with less than thirty percent of the nameplate rating for the months of February, May, November and December 2011 and January 2012. There was no documentation stating the generator reached operating conditions or a record of the exhaust gas temperatures. This was confirmed by the Maintenance Assistant at the time of record review.</p> <p>3.1-19(b)</p>		credible allegations of compliance.		