

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155118	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 787 N DETROIT ST LAGRANGE, IN 46761
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/09/12</p> <p>Facility Number: 000049 Provider Number: 155118 AIM Number: 100270890</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 one story facility was determined to be of Type V (111) construction and was fully sprinklered except for the front entrance awning. The original building was constructed in 1968 with the northeast, southeast and kitchen added in</p>	K0000	Please accept this as credible allegation of compliance to the findings of ISDH, Life Safety survey dated 8/9/2012.	

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>1978. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 93 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, however, in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered except under the front entrance awning. The facility has one detached garage for facility storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/15/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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. Based on observations and interview, the facility failed to ensure 2 of 2 sets of dining room corridor doors on the Alzheimer wing would latch into their frames and were smoke resistant. This deficient practice could affect 20 residents on Alzheimer wing which is adjacent to the Alzheimer dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 8/09/12 at 1:20 p.m. with the Maintenance Supervisor, the south set of corridor doors leading into the Alzheimer dining room on the Alzheimer wing would not latch into the door frame. Furthermore, the north and south set of corridor doors leading into</p>	K0018	<p>All residents are at risk to be effected by this deficient practice. There are no corridor doors leading into the Alzheimer's dining room. Latches were installed on the top of the north and south corridor doors leading into the main dining room, that latch into the frame when the doors shut on 8/24/2012. Weather stripping was installed on the north and south corridor doors leading into the main dining room, to make them smoke resistant. The Maintenance Director or his designee will monitor the latches and weather stripping to determine they are in working order weekly x 1 month, then every other week x 1 month, then monthly, ongoing to ensure continued compliance. See attachment # 1.</p>	08/24/2012

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	<p>the Alzheimer dining room were not smoke resistant because of a one half inch gap between the doors when closed. Based on interview on 8/09/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned doors would either not latch into their frames or were not smoke resistant..</p> <p>3.1-19(b)</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on central hall such as rooms with combustibile items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 22 residents on central hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/09/12 at 1:55 p.m. with the Maintenance Supervisor, the central supply room on central hall contained forty four cardboard boxes. The central supply room was greater than fifty square feet in size and the door to the room was not equipped with a self closing device. Based on interview on 08/09/12 at 1:58 p.m. with the Maintenance</p>	K0029	All residents are at risk to be effected by this deficient practice. An automatic door closer was installed on the Central Supply Room on the Central hall on 8/14/2012. This is the only Central Supply room in our facility. There is no need to monitor this as it is the only Central Supply room we have.	08/14/2012			

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	<p>Supervisor, it was acknowledged the aforementioned door leading into the central supply room was not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p>			

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K0047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observations and interview, the facility failed to provide directional signs for 1 of 12 exit discharge means of egress. LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. This deficient practice could affect 6 residents in the Main dining room on central hall west, including visitors and staff who could misinterpret which direction to go as a possible escape route out away from the facility during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation on 08/09/12 at 2:27 p.m. with the Maintenance Supervisor, there were no directional arrows outside the Main dining room west exit so evacuees could quickly determine the path of exit discharge to a public way. Once outside the Main dining room west exit, turning left would direct evacuees back inside the building, but turning right led to a public way. Based on interview on 08/09/12 at 2:30 p.m., it was acknowledged by the Maintenance Supervisor the direction to go right or left</p>	K0047	<p>All residents and visitors are at risk to be effected by this deficient practice. A directional sign stating, "Emergency Exit", with an arrow pointing to the right, towards the parking lot, a public way, was ordered on 8/23/2012. It will be placed, on a pole, at the end of the side walk as you walk out of the main dining room west exit, where it will be clearly visible to those using this exit. It will be lighted by the exterior building emergency egress lighting. This will be complete by 9/8/2012. There is no need to monitor this because it is the only door that has a sidewalk that does not lead to a public way.</p>	09/08/2012
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	once outside the Main dining room west exit could not be determined without exit directional signs being clearly posted. 3.1-19(b)				

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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 observations and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 2 exits with outside canopies in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 22 residents on center hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 08/09/12 at 1:35 p.m. with the Maintenance Supervisor,</p>	K0056	The canopy outside the front entrance is constructed of non combustible material. See attachment # 2a & 2b. This is the only exit with a canopy on our facility, not 2 as indicated. This fire rating will be added to the TELS Preventative Maintenance Program for future reference. No canopies will be added to our facility that are not constructed of non combustible material. There is no need to monitor this as this is the only entrance with a canopy over it.	08/14/2012

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	<p>the canopy outside the front entrance was not provided with sprinkler coverage. The outside canopy was attached to the building, extended fifteen feet from the the building and was constructed of aluminum supports with a cloth covering for the roof. Based on interview on 08/09/12 concurrent with the observation with the Maintenance Supervisor, it was acknowledged there were no sprinkler heads present for the canopy outside the front entrance to provide complete sprinkler coverage for the facility nor was any fire rated documentation for the cloth covering offered for review.</p> <p>3.1-19(b) 3.1-19(ff)</p>				

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K0062 SS=E	<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 provide a complete supply of spare sprinklers for 2 of 2 automatic sprinkler systems in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect 20 residents on the Alzheimer wing including staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 08/09/12 at 2:45 p.m. with the Maintenance Supervisor, there were no glass tube type sprinkler</p>	K0062	<p>All residents living in the alzheimer's Unit are at risk to be effected by this deficient practice. SafeCare was here to assess the situation on 8/24/2012. SafeCare will replace the 2 glass tube sprinkler heads with 2 wet standard response sprinklers to match the other sprinklers in the Alzheimer's unit dining room on 9/6/2012. See attachment # 3. SafeCare provided us with 2 of the glass tube type sprinkler heads to match those in the remaining parts of the facility. The Maintenance Director or his designee will monitor the availability of replacement sprinkler heads monthly to ensuire continued compliance. See attachment # 4.</p>	09/08/2012

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	<p>heads in the spare sprinkler cabinets. Based on interview on 08/09/12 at 2:50 p.m. with the Maintenance Supervisor, it was acknowledged the spare sprinkler cabinets located by the northwest and northeast exits did not have any glass tube type sprinkler heads as spares for sprinklers in the Alzheimer dining room.</p> <p>3.1-19(b)</p>			

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation, record review and interview, the facility failed to provide flame resistant window curtains in 1 of 16 rooms on the Alzheimer wing. This deficient practice could affect 20 residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/09/12 at 2:10 p.m. with the Maintenance Supervisor, the window curtains installed in the quiet room on the Alzheimer wing lacked attached documentation confirming they were inherently flame resistant. Based on record review and interview on 08/09/12 at 3:45 p.m. with the Maintenance</p>	K0074	The sheer curtain in the Quiet Room in the Alzheimer's Unit is made of non combustible material. See attachment # 5. This is the same sheer curtain that is used throughout the facility. This fire rating will be added to the TELS Preventative Maintenance Program for future reference. The facility will have fire ratings available for a ny window treatments installed in the future. There is no need to monitor this as all sheer curtains in our facility are made of this same material.	08/14/2012			

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	Supervisor, it was acknowledged there was no documentation regarding flame resistance available for review for the window curtains in the quiet room on the Alzheimer wing. 3.1-19(b)				