

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155573	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 981 BEECHWOOD AVE MIDDLETOWN, IN 47356
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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: 10/14/15</p> <p>Facility Number: 000342 Provider Number: 155573 AIM Number: 100289140</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 fully sprinkled. 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 sleeping rooms. The facility has a capacity of 60 and had a census of 33 at the time of this visit.</p>	K 0000	Please accept this plan of correction as our credible allegation of compliance. We respectfully request consideration for paper compliance for these deficiencies due to the low number of deficiencies and low scope and severity.	
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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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K 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached wooden storage building which was not sprinkled.</p> <p>Quality Review completed on 10/19/15 - DA</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 2 of 4 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice affects 16 residents who reside on the West Hall and 10 residents who reside on the East Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 10/14/15</p>	K 0025	<p>Plan of Correction for Middletown 2567 10.14.15 We respectfully request paper compliance for this plan of correction. Please contact Alaina Butiste, H.F.A., Interim Administrator Miller's Merry Manor of Middletown, 765-354-2278 if there is a need for any more information. K025 It is Miller's Merry Manor's Policy to maintain compliance with Life Safety Code, including continuous, intact smoke barriers with a minimum of one half hour fire rating. The gap on the smoke</p>	10/30/2015			

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	<p>during a tour of the attic smoke barriers from 12:15 p.m. to 12:45 p.m., the West Hall attic smoke barrier wall had a six inch by four inch square area of concrete missing in the center of the attic smoke barrier wall and the East Hall attic smoke barrier wall had a two inch gap around a four inch sprinkler pipe penetration not fire stopped. This was verified by the maintenance supervisor at the time of observations and acknowledged by the maintenance supervisor at the exit conference on 10/14/15 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p>barriers was eliminated on 10/22/2015. The six inch by four inch square area was filled in by using a base of mesh and filling in with concrete, creating a continuous seal. The two inch gap around the sprinkler pipe was filled in using intumescent fire caulk to create a continuous seal. This deficient practice could have potentially affected 10 residents who reside on the East hall, 16 residents who reside on the West hall. The following measures have been implemented to ensure the deficient practice does not recur. The Maintenance Director was in-serviced (Attachment E) by the administrator on 10/30/15 regarding facility protocol for vendor notification, as well as continuous monitoring following vendor service to ensure continuous, intact smoke barriers. The facility will also give notice to all vendors upon arrival of our request that they inform the Maintenance Director of any need to create an opening in any barrier (Attachment G). The facility's Maintenance Director will use the QA tool titled "Post-Vendor Inspection" to ensure all smoke barriers are intact (Attachment F) once a month for 3 months and then quarterly thereafter. The QA committee will review and make recommendations as necessary. These changes will be completed by October 31, 2015.</p>		

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K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 34 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affect 16 residents who reside on the West Hall and use the West Hall shower room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 10/14/15 at 11:30 a.m., the West Hall shower room ceiling had an electric receptacle on the</p>	K 0147	<p>Plan of Correction for Middletown 2567 10.14.15</p> <p>We respectfully request paper compliance for this plan of correction. All of the attachments to indicate we are meeting the requirements of NFPA 70, National Electrical Code 9.1.2 are attached in our Plan of Correction. Please contact Michelle Watkins, H.F.A., Miller's Merry Manor of Middletown, 765-354-2278 if there is a need for any more information.</p> <p>K147</p> <p>It is the policy of Miller's Health Systems, Inc. to</p> <p>This deficient practice could have potentially affected 16 residents who use the West Hall shower room.</p> <p>The following measures have been implemented to ensure the deficient practice does not recur. The facility's Maintenance Director will use the QA tool titled "Maintenance Services Review" to ensure all equipment is safe and functioning properly (Attachment C).</p> <p>To ensure this deficient practice</p>	10/20/2015	

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	ceiling between the two shower stalls with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breakers for the West Hall shower room was not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observation and acknowledged by the maintenance supervisor at the exit conference on 10/14/15 at 12:55 p.m. 3.1-19(b)		does not recur, the facility's Maintenance Director will use the QA "Maintenance Services Review" once a month (Attachment D) for 3 months, then quarterly thereafter. The QA committee will review and make recommendations as necessary. The outlet was removed on 10/19/15 and a cover was placed over the site.		