

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155053	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 612 E 11TH ST RUSHVILLE, IN 46173
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 02/06/14</p> <p>Facility Number: 000018 Provider Number: 155053 AIM Number: 100273930</p> <p>Surveyor: Mark Bugni, 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke</p>	K010000		

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>detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 98 and had a census of 79 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two detached wooden storage buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 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 1¼ 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 observation and interview, the facility failed to ensure 4 of 126 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects 4 residents who reside in resident rooms 62 and 63.</p> <p>Findings include:</p> <p>Based on observations on 02/06/14 during a tour of the facility from 10:30 a.m. to 1:00 p.m. with the maintenance supervisor, the door to resident room 62, the door to resident room 63, the medical supply room door, and the door to the receptionist storage room each had between a three quarter inch and one half inch gap along the top and latching</p>	K010018	Doors were immediately fixed to prevent the gap between three quarter inch and one half inch along the top and latching sides of the doors with the doors closed. All other doors in the facility checked and no gaps found greater than 1/8" found. Maintenance director or designee will conduct audit title "Rooms Inspection" (Attachment A) in maintenance system TELS every quarter to ensure doors do not have gaps greater than 1/8" or less. Maintenance director or designee will check a minimum of 10 doors daily x 1 week, weekly x 4 weeks, and monthly x 6 months using QA Tool titled "Life Safety Code Audit" (Attachment B) to ensure there are no gaps greater than 1/8" found in doors. Systematic changes will be completed by February 21, 2014.	02/21/2014			

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K010025 SS=A	<p>sides of the doors with the doors closed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 1:20 p.m. exit conference on 02/06/14.</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 1 of 126 room wall smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice does not affect any residents.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K010025	<p>Wall was immediately repaired. No residents were affected by this deficient practice. Maintenance director or designee will conduct audit title "Rooms Inspection: Non-Resident Room Inspection" (Attachment D) in maintenance system TELS every quarter to ensure smoke barrier walls are maintained to provide a one half hour fire resistance rating. Maintenance director or designee will monitor a minimum of 10 doors daily x 1 week, weekly x 4 weeks, and monthly x 6 months using QA Tool titled "Life Safety</p>	02/21/2014			

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K010062 SS=E	<p>maintenance supervisor on 02/06/14 at 12:20 p.m., the administrators' office south wall had a six inch by four inch square area of drywall missing with bare wooden studs exposed. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/06/14 at 1:20 p.m.</p> <p>3.1-19(b)</p> <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 replace 6 of over 300 sprinklers in the facility covered in corrosion and paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 20 residents who</p>	K010062	<p>Code Audit" (Attachment B) to ensure smoke barrier walls are maintained to provide a one half hour fire resistance rating. Systematic changes will be completed by February 21, 2014.</p> <p>Sprinklers identified were replaced with new sprinklers and/or paint removed. All sprinklers in the facility were check and no other sprinklers found covered in corrosion and paint. Maintenance director or designee will conduct monthly audit titled "Sprinkler System" (Attachment C) to maintenance system TELS to ensure sprinklers are not covered in corrosion and paint. Maintenance director or designee will check a minimum of 10 doors daily x 1 week, weekly x 4 weeks, and monthly x 6 months using QA Tool titled, "Life Safety Code Audit" (Attachment B) to ensure sprinklers are not covered</p>	02/21/2014			

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	<p>use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 02/06/14 during a tour of the facility from 10:30 a.m. to 1:00 p.m. with the maintenance supervisor, the sprinkler in the Service Hall corridor outside the laundry room and the sprinkler in the Service Hall corridor outside the employee lounge were both completely covered in green corrosion. Furthermore, the sprinklers in the East Wing, North Hall shower room stall two, the East Wing, North Hall clean utility room, resident room 28 closet, and the dietary office were completely covered in white paint. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/06/14 at 1:20 p.m.</p> <p>3.1-19(b)</p>		<p>in corrosion and paint. Systematic changes will be completed by February 21, 2014.</p>		

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K010143 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a self closing 45 minute fire rated door. This deficient practice does not affect any residents, since the Service Hall is a staff only area.</p> <p>Findings include:</p> <p>Based on observation on 02/06/14 at 11:35 a.m. with the maintenance supervisor, the liquid oxygen storage room located in the Service Hall, was not provided with a self closing device. Based on an interview with the maintenance supervisor on 02/06/14 at 11:40 a.m., nursing staff transfer liquid oxygen into small portable containers</p>	K010143	<p>A self closing device was added to the liquid oxygen storage/transfer room door. No residents were affected by this deficient practice. Maintenance director or designee will conduct audit titled "Liquid Oxygen Room: Self Closing Device" (Attachment E) every quarter to ensure the liquid oxygen storage/transfer room self closing device is working correctly. Maintenance director or designee will monitor liquid oxygen storage/transfer room daily x 1 week, weekly x 4 weeks, and monthly x 6 months using QA Tool titled "Life Safety Code Audit" (Attachment B) to ensure the liquid oxygen storage/transfer room self closing device is working correctly. Systematic changes will be completed by February 21, 2014.</p>	02/21/2014			

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	<p>for resident use in the oxygen storage. The lack of a self closing device on the liquid oxygen storage/transfer room was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/06/14 at 1:20 p.m.</p> <p>3.1-19(b)</p>			