STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000				
	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). Survey Date: 02/15/12 Facility Number: 000154 Provider Number: 155251 AIM Number: 100289680 Surveyor: Dennis Austill, Life Safety Code Survey Supervisor 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. The original one story facility consisting of the west wing and administrative area with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. A later one story addition, consisting of the east wing constructed prior to March 2003, was	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	determined to be Type V (III) also fully sprinklered therefore it was surveyed as one building in accordance with LSC Chapter 19. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. All resident rooms were provided with battery-operated smoke detectors. The facility has a capacity of 110 and had a census of 70 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/16/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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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 business offices was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet 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 automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any residents, staff or visitors in the vicinity of the business office.	K0017	K 017 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K017. I. All residents, staff and visitors have the potential to be affected by this deficient practice.II. To correct the deficient practice our vendor, Safe Care, installed an electronically supervised automatic smoke detection system in the business office on 2/21/12.III. To ensure the deficient practice does not recur all rooms without a fire resistant barrier were audited to ensure that an electronically supervised automatic smoke detection system was installed. All areas were found to be in compliance. IV. The corrective actions will be monitored by the Maintenance Supervisor or designee.	02/29/2012

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility at 10:35 a.m. on 02/15/12, the business office near the main entrance had a double sliding glass window to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the office area was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the reception office was not protected by an electrically supervised smoke detection system. 3.1-19(b)		Monitoring five days a week will be done by the Maintenance Supervisor or designee to ensure that the smoke detectors are operating properly via the TELS system. Instructions were printed from our Electronic Preventative Maintenance database (Attachment 1-3 pages). V. These changes were made by 2/21/12	

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K0025 SS=E	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			
	Based on observation and interview, the facility failed to ensure the passage of cable through 3 of 6 smoke barriers was protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any staff, visitors and residents using the corridor if smoke from a fire were to infiltrate the protective barriers. Findings include: Based on observation on 02/15/12 between 1:30 p.m. and 2:30 p.m. with the Maintenance Supervisor and Maintenance	K0025	K 025 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K025. I. All residents, staff and visitors have the potential to be affected by this deficient practice.II. To correct the deficient practice exposed penetrations were sealed with fire rated caulk. III. To ensure the deficient practice does not recur all building service material were audited to ensure that the space between penetrating items and smoke barrier were filled with a material capable of maintaining smoke resistance. Any areas found to have deficiencies were corrected immediately. IV. The corrective actions will be monitored by the Maintenance Supervisor or designee. The Maintenance Supervisor of designee will complete the Quality Assessment Tool, “Post Ceiling Penetration Audit” (Attachment 2 -1page) will be completed within	02/29/2012

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	Assistant, there were exposed penetrations through the smoke barrier above the ceiling tiles at the following locations that were not firestopped and/or not firestopped properly: a) The smoke barrier near room 115 had two penetrations with one inch annular space around a data cable running through the penetrations that were not sealed. b) The smoke barrier near the Administrators office had three penetrations with one inch annular space around a data cable running through the penetrations that were not sealed. c) The smoke barrier near room 113 had two penetrations with one inch annular space around a data cable running through the penetrations that were not sealed. d) The smoke barrier near room 113 had three additional penetrations that had been sealed with expanding foam. Based on interview during the times of observation, the Maintenance Assistant acknowledged the unprotected openings had been recently created by the facility running Ethernet cables through the smoke barriers for security cameras. 3.1-19(b)		24 hours of completion of any work. V. These changes were made by 2/17/12.	

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K0029 SS=E	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			
	Based on observation and interview, the facility failed to ensure 2 of more than 15 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the hazardous areas. Findings include: Based on observations with the Maintenance Supervisor and Maintenance Assistant on 02/15/12 between 10:30 a.m. and 12:30 p.m., room 136 exceeded 50 square feet in size, was being used for combustible material storage such as cardboard boxes and lacked a door closer. The kitchen door separating the kitchen from the dining room had a door closer but failed to latch into the door frame. Based on interview during the times of observation, the Maintenance Supervisor acknowledged room 136 lacked a door closer and the kitchen/dining room door	K0029	K 029 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K029. I. All residents, visitors and staff have the potential to be affected by this deficient practice. II. To correct the deficient practice a door closer was installed for room 136 and the latch was repaired on the kitchen door. To ensure the deficient practice does not recur all door latches were inspected. Any areas found with deficiencies were repaired immediately.III. The corrective actions will be monitored by the Maintenance Supervisor or designee. The Quality Assurance Tool “Interior Room Door Inspection” (Attachment 3-1 page) will be completed weekly for four weeks, monthly for three months and quarterly thereafter. IV. These changes were made by 2/16/12.	02/29/2012

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	did not latch. 3.1-19(b)			

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K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.			
	Based on record review and interview, the facility failed to ensure 3 of 5 battery operated exterior emergency lights were tested annually in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any occupant in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: Based on review of "Monthly Preventative Maintenance Reports" with the Maintenance Assistant on 02/15/12 at 9:30 a.m., there was no written record of an annual test regarding the two battery operated emergency lights in the therapy room and the one battery operated emergency light in the basement available	K0046	K 046 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K046. I. All residents, visitors and staff have the potential to be affected by this deficient practice. II. To correct the deficient practice lights in physical therapy were replaced and the basement light was tested and met the 90 minute requirement. III. To ensure the deficient practice does not recur this task has been added to our yearly generator test run which is conducted in August of every calendar year. IV. The corrective actions will be monitored by the Maintenance Supervisor or designee. Instructions were printed out for the Maintenance Supervisor or designee (Attachments 4-2 pages). These will be conducted yearly in August. V. These changes were made by 2/16/12.	02/29/2012

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	for review. The Maintenance Assistant during the time of record review, acknowledged the documentation did not include an annual 90 minute test for the aforementioned battery operated emergency lights. 3.1-19(b)			

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K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of "Fire and Evacuation Drill/Event Form" reports" with the Maintenance Assistant at 10:00 a.m. on 02/15/12, fire drills were not documented for the second shift of the first quarter of 2011 or for the third shift of the third quarter of 2011. The Maintenance Assistant during the time of record review, acknowledged there was no other documentation available for review to verify these drills were conducted. 3.1-19(b) 3.1-51(c) 2) Based on record review and interview,	K0050	K 050 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K050. I. All residents, staff and visitors have the potential to be affected by this deficient practice.II. To correct the deficient practice a schedule for all fire drills for 2012 was established assuring that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift (Attachment 5 – 1 page) III. To ensure the deficient practice does not recur the Safety Director who is responsible for conducting fire drills was reinserviced on policy and procedure for conducting fire drills at unexpected times under varying conditions. IV. The corrective actions will be monitored by the Maintenance Supervisor or designee. The Maintenance Supervisor of designee will be responsible to monitor for compliance on a monthly basis while entering	02/29/2012

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	the facility failed to conduct fire drills at unexpected times under varying conditions in 9 of 12 fire drills. This deficient practice affects all residents in the facility including staff. Findings include: Based on review of "Fire and Evacuation Drill/Event Form" reports" with the Maintenance Assistant at 10:00 a.m. on 02/15/12, nine fire drills were conducted near or on the the end of the month as follows: 02/25/11, 03/31/11, 04/29/11, 05/30/11, 06/30/11, 07/31/11, 08/30/11, 10/31/11 and 12/29/11. Based on interview at the time of record review, the Maintenance Assistant acknowledged fire drills were often conducted near or at the end of each month. 3.1-19(b) 3.1-51(c)		documented times of fire drills in TELS system.V. These changes were made by 2/27/12	

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K0056 SS=E	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			
	Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided above 1 of 3 commercial laundry dryers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect any resident, staff and/or visitors using the main corridor outside the laundry. Findings include: Based on observations with the Maintenance Supervisor at 11:55 a.m. on 02/15/12, the access area behind the dryers in the laundry lacked complete coverage from the sprinkler system. Specifically, dryer # 3 lacked coverage from a sprinkler head. The one sprinkler head above the three dryers provided	K0056	K 056 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K056. I. All residents, staff and visitors have the potential to be affected by this deficient practice.II. To correct the deficient practice a sprinkler will be installed by our vendor, Safe Care, on 2/29/12 (Attachment 7-3 pages).III. To ensure the deficient practice does not recur all sprinkler heads were audited to ensure that no objects were obstructing the sprinkler head. IV. The corrective actions will be monitored by the Maintenance Supervisor or designee. Monitoring five days a week will be done by the Maintenance Supervisor or designee to ensure that the sprinkler system is operating properly via the TELS system. Instructions were printed	02/29/2012

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	coverage for dryers # 1 and # 2 but there was an exhaust duct between dryers # 2 and # 3 that would obstruct coverage from the available sprinkler head. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the available sprinkler head would not provide coverage above dryer # 3. 3.1-19(b)		from our Electronic Preventative Maintenance database for a wet system (Attachment 6-1 page). V. These changes will be made by 2/29/12	

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K0067 SS=E	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2			
	Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 24 of 76 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A 2-3.11.1 requires that egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors on the Northeast and Southeast wings. Findings include: Based on observation on 02/15/12 between 10:30 a.m. and 12:30 p.m. with the Maintenance Supervisor and Maintenance Assistant, the following rooms were using the egress corridor as a return air system: 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 111, 112, 113, 114, 115, 116, 117, 118 and 119. Heating and cooling are supplied by floor vents in the rooms and rely on the	K0067	K 067 NFPA 101 Life Safety Code StandardThe facility respectfully submits the following plan of correction as a credible allegation of compliance to the above mentioned regulation, prefix K067.We have applied for a continuing annual waiver. Please see attached documentation (Attachment 8-4 pages).	02/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	corridor for return ventilation. These rooms are located in the 1973 addition to the building but do not include the therapy room and resident rooms 101, 103, 105, 107 and 109. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the egress corridor served as the return air plenum for the HVAC system in this portion of the facility. 3.1-19(b)			