

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155581	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 500 E PICKWICK DR SYRACUSE, IN 46567
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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: 08/26/13</p> <p>Facility Number: 000566 Provider Number: 155581 AIM Number: 100267450</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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000		
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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>capacity of 66 and had a census of 45 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/29/13.</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 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 observation and interview, the facility failed to ensure there was no impediments to the closing of 1 of 2 Rehabilitation center corridor doors. This deficient practice could affect approximately 4 residents in the Rehabilitation center and any resident at the nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 08/26/13 at 1:05 p.m., the left corridor door to the Rehabilitation center was propped open with a plastic door wedge. This was acknowledged by the Administrator and the Maintenance Supervisor.</p>	K010018	<p>K 018 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 018. All residents have the potential to be affected by this practice. All plastic door wedges have been removed from the facility. The door to the Rehabilitation Center has been adjusted to stay open with out any impediments assisting. This was completed on August 30, 2013. Maintenance Supervisor or Designee will monitor 10 rooms per week for 3 months and then 10 rooms monthly after that, to insure no impediments are blocking the doors (Attachment A: Life Safety Code Door Review). Results will be reviewed by Administrator weekly and by the QA Committee monthly. All changes will be completed by</p>	09/25/2013			

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	3.1-19(b)		9-25-13.		

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K010025 SS=D	<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 1 ceiling 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 was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and Maintenance Supervisor on 08/26/13 at 12:33 p.m., there was an unsealed penetration in the ceiling of the medication room measuring one fourth inch around computer lines. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010025	<p>K 025 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 025. All residents and staff have the potential to be affected by this practice. The penetration in the ceiling of the Medication Room has been sealed. This was completed on August 27, 2013. To insure that there no other penetrations in the ceilings of the facility, the Maintenance Supervisor or designee will monitor 10 rooms per week for 3 months and then 10 rooms monthly after that. (Attachment B: Life Safety Code Fire Wall and Ceiling Review). Results will be reviewed by Administrator weekly and by the QA Committee monthly with all deficiencies being fixed immediately. All changes will be completed by 9-25-13.</p>	09/25/2013	

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K010029 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 the corridor door to 1 of 1 storage rooms in the Lakeshore Pod with combustibles, measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect 18 resident in the Lakeshore Pod.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 08/26/13 at 12:50 p.m., the corridor door to resident room 212 with 20 boxes of resident and office files, measuring 216 square feet in size, lacked a self closing device. This was confirmed by the Administrator and the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>	K010029	<p>K 044 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 044. All residents have the potential to be affected by this practice. A self closing device has been added to resident room 212's door. This was completed on August 30, 2013. Maintenance Supervisor or designee will monitor all rooms that require a self closing device to insure that all are working properly weekly for 3 months then every month after that (Attachment A: Life Safety Code Door Review). Results will be monitored by Administrator weekly and by the QA Committee monthly with all deficiencies being fixed immediately. All changes will be completed by 9-25-13.</p>	09/25/2013			

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 manual hood fire extinguishing activation devices was located in the path of egress. Section 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96 at Section 7-5.1 states a readily accessible means for manual activation shall be located between 42 inches and 60 inches above the floor, located in a path of exit or egress, and clearly identify the hazard protected. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 08/26/13 at 1:25 p.m., the activation device for the kitchen hood fire protection system was mounted on the wall behind the steam table. The steam table extended from the wall 42 inches and required the kitchen staff to reach over hot food and steam in order to activate the kitchen hood fire protection system. Measurements were provided by</p>	K010069	K 069 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 069. All residents and staff have the potential to be affected by this practice. The manual hood fire extinguishing activation device was moved to a point of exit or egress next to the exit door that separates the Kitchen from the Dining Room on August 27, 2013. The device has been placed at a height of 52 inches above the floor. To insure the device is working and in the correct position the Maintenance Supervisor or Designee will monitor the device weekly for 4 weeks and monthly after that (Attachment C: Life Safety Code Review). All Results will be reviewed by the Administrator weekly and with the QA Committee monthly. All changes will be completed by 9-25-13.	09/25/2013			

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	the Maintenance Supervisor at the time of observations. 3.1-19(b)				

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 4 fire barrier walls was protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p>	K010130	<p>K 130 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 130. All residents and staff have the potential to be affected by this practice. The fire wall has been filled with a fire resistant barrier to seal the fire wall and the pipe on August 28, 2013. To insure that the fire walls are sealed, all 4 fire walls will be monitored by Maintenance Supervisor or designee each week for 4 weeks and then monthly after that (Attachment B: Life Safety Code Fire Wall and Ceiling Review). Results will be monitored by Administrator weekly and with the QA committee monthly with all deficiencies being fixed immediately. The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 130. All residents and staff have the potential to be affected by this practice. The batteries in all 36 resident rooms have been changed on August 29, 2013 to put us back in to compliance. The checking of the batteries should be done quarterly and changing of batteries should be done annually and will be placed on a schedule on our TELS Maintenance system to be changed a month before the expiration date. To insure that</p>	09/25/2013			

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	<p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/26/13 at 1:36 p.m., there was an unsealed penetration around a main sprinkler line above the drop down ceiling in the Teal Pod fire wall. Based on an interview with the Maintenance Supervisor at the time of observation, the sprinkler line was recently replaced and there was a gap around the sprinkler line measuring from one fourth inch to two inches.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 36 of 36 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice</p>		<p>the batteries are checked and changed Maintenance Supervisor or Designee will check a room daily for 1 month (Attachment D: Daily Smoke Detector Check List), one pod (12 Rooms), monthly for 3 months (Attachment F: Monthly Smoke Detector Check List), then the all 3 pods quarterly there after with the batteries being changed in July of 2014 (Attachment E: Smoke Detector Quarterly Check and Annual Change Form). All corrections will be completed by 9-25-13.</p>				

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	<p>affects any of the 45 residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 08/26/13 during the tour from 12:00 p.m. to 2:00 p.m., the resident rooms had battery operated smoke detectors. Based on an interview with the Maintenance Supervisor during the record review process at 12:10 p.m., he had not replaced the batteries in the resident rooms' smoke detectors since the initial installation in April of 2012.</p> <p>3.1-19(b)</p>				

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with a fully functioning alarm annunciator panel in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 	K010144	K 144 The facility respectfully submits the following plan of correction as a credible allegation of compliance for regulation K 130. All residents have the potential to be affected by this practice. The light on the low fuel indicator has been replaced and working. This was completed on August 26, 2013. To insure the lights on the panel are working Maintenance Supervisor or designee will test panel once a week for 4 weeks and monthly there after (Attachment C: Life Safety Code Review). Results will be monitored by Administrator weekly and with the QA committee monthly. All changes will be completed by 9-25-13.	09/25/2013			

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	<p>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 08/26/13 at 12:30 p.m., when the lamp test button on the emergency generator remote annunciator panel was pushed the lamps next to the low fuel did not illuminate. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3-1.19(b)</p>				