DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155128	A. BUILDING -- B. WING	04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S AT OAK POINTE	411 N WOLF RD COLUMBIA CITY, IN 46725

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/10/19 Facility Number: 000055 Provider Number: 155128 AIM Number: 100288410 At this Emergency Preparedness survey, Miller's at Oak Pointe was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 82 and had a census of 42 at the time of this survey. Quality Review completed on 04/11/19	E 0000	Please accept the following Plan of Correction as the buildings credible allegation of compliance. The facility respectfully requests consideration of paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/10/19 Facility Number: 000055 Provider Number: 155128 AIM Number: 100288410 At this Life Safety Code survey, Miller's at Oak Pointe was found not in compliance with Requirements for Participation in	K 0000	Please accept the following Plan of Correction as the buildings credible allegation of compliance. The facility respectfully requests consideration of paper compliance.	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 82 and had a census of 42 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached barn providing facility services including storage of beds and other maintenance equipment that was not sprinklered. Quality Review completed on 04/11/19			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised			

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	automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. 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 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents in the 100 hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and the Administrator on 04/10/19 at 12:10 p.m., the set of fire doors that separated health care from assisted living had a half inch gap where the doors came together. This condition would not limit the spread of smoke from one side of the fire barrier to the other. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed there was a gap where the doors come together and would not restrict the movement of smoke and provided the measurements. 3.1-19(b)	K 0131	K 131 – Multiple Occupancies This deficient practice has the potential to affect 25 residents on the 100 hall. An audit of the facility was conducted on 4/10/19 to locate any other potential deficient fire doors with gaps between the doors. No other findings were noted at that time. On or before 5/10/19, the facility vendor will install an astragal on the fire door located at the end of the 100 hall separating the health care facility from the assisted living facility. The Maintenance Director or other designee will be responsible to complete the QA Tool “Environmental Services Review” (Attachment A) daily x7 days, then 3x weekly for a minimum of 8 weeks to meet compliance rate of 100%. Once the facility achieves 100% compliance the tool will continue to be completed monthly for a minimum of 6 months to monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QA tracking log. The facility QA team meets	05/10/2019

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			monthly for QAPI and any QA tracking logs are reviewed by the team to ensure ongoing compliance and performance improvement.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7			
	Based on observation and interview, the facility failed to ensure 1 of 9 exit discharge had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents using the 200 hall emergency exit. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Administrator on 04/10/19 at 12:40 p.m., the last section of the concrete exit discharge for exit 18 was deteriorating leaving loose gravel, had large cracks, and was uneven. Based on interview at the time of observation, the Maintenance Director acknowledged the walkway for exit 18 was in need of some repair to have a complete level walking surface that was free of obstructions leading to the common way.	K 0271	K 271 – Discharge from Exits This deficient practice has the potential to affect 25 residents using the 200 hall emergency exit located at door 18. An audit of the facility was conducted on 4/10/19 to locate any other potential deficient concrete exit walk ways. No other findings were noted at that time. On 4/17/19, the facility vendor repaired the last section of concrete outside the 200 hall emergency exit located at door 18. The deteriorated loose gravel was removed and filled with new concrete. See Attachment B for pictures. The Maintenance Director or other designee will be responsible to complete the QA Tool "Environmental Services Review" (Attachment A) daily x7 days,	05/10/2019

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	3.1-19(b)		then 3x weekly for a minimum of 8 weeks to meet compliance rate of 100%. Once the facility achieves 100% compliance the tool will continue to be completed monthly for a minimum of 6 months to monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QA tracking log. The facility QA team meets monthly for QAPI and any QA tracking logs are reviewed by the team to ensure ongoing compliance and performance improvement.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler			

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	Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 housekeeping offices with combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 25 residents in the 200 hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 04/10/19 at 12:40 p.m., the housekeeping office contained over 20 boxes of supplies, was greater than 50 square feet, and did not have a self-closing door. Based on interview at the time of observation, the Maintenance Director agreed the Housekeeping Office was used as storage for boxes and cleaning supplies, was larger than 50 square feet, and the door was not self-closing. The Maintenance Director did state the door was new and the self-closer was not re-installed. 3.1-19(b)	K 0321	K 321 - Hazardous Areas - Enclosure This deficient practice has the potential to affect 25 residents in the 200 hall. An audit of the facility was conducted on 4/10/19 to locate any other combustible storage rooms with greater than 50 square feet without a self-closing device. No other findings were noted at that time. On 4/10/19 a self-closing device was added to the housekeeping office. See Attachment C for pictures of the self closing device installed. The Maintenance Director or other designee will be responsible to complete the QA Tool “Environmental Services Review” (Attachment A) daily x7 days, then 3x weekly for a minimum of 8 weeks to meet compliance rate of 100%. Once the facility achieves 100% compliance the tool will continue to be completed monthly for a minimum of 6 months to	05/10/2019

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			monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QA tracking log. The facility QA team meets monthly for QAPI and any QA tracking logs are reviewed by the team to ensure ongoing compliance and performance improvement.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director and the Administrator on 04/10/19 at 11:10 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator but was unaware of the fuel quality testing requirements. 3.1-19(b)	K 0918	K 918 –Electrical Systems – Essential Electric System This deficient practice has the potential to affect all residents in the facility. On or before 5/10/19 the facility will have completed the annual fuel quality test on the facility's diesel powered generator. The Maintenance Director or other designee will be responsible to complete the QA Tool "Environmental Services Review" (Attachment A) daily x7 days, then 3x weekly for a minimum of 8 weeks to meet compliance rate of 100%. Once the facility achieves 100% compliance the tool will continue to be completed monthly for a minimum of 6 months to monitor for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QA tracking log. The facility QA team meets monthly for QAPI and any QA tracking logs are reviewed by the team to ensure ongoing compliance and performance improvement.	05/10/2019