

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2016
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NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
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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: 08/11/16</p> <p>Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280</p> <p>At this Life Safety Code survey, Byron Health Center 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 four story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors have been installed in all resident rooms. The facility has a capacity of 191 and had a census of 89 at</p>	K 0000		
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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 0038 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered.</p> <p>Quality Review completed on 08/15/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview the facility failed to ensure 2 of 18 corridors were maintained to provide adequate headroom. LSC 7.1.5 requires the means of egress shall be designed and maintained to provide adequate headroom as provided in other sections of this Code and shall not be less than 7 foot 6 in. with projections from the ceiling not less than 6 ft. 8 inches nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft. 8 in. This deficient practice could affect up to 43 residents, staff and visitors in the facility that would use these basement corridors.</p>	K 0038	<p>This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</p> <p><u>K 038 NFPA 101 Life Safety Code Standards</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The cited corridors are not</p>	09/10/2016

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K 0062	<p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations on 08/11/16 from 09:15 p.m. to 11:00 a.m., the following areas in the basement failed to provide adequate headroom:</p> <p>a.) The basement ceiling height in the east-west corridor measured six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along the 70 foot corridor that measured five feet seven inches from the floor.</p> <p>b.) The ceiling height at the south basement corridor smoke barrier wall measured five feet nine inches. Additionally, there was a pipe protruding below the ceiling which ran along the center basement corridor that measured six feet from the floor and the north-south corridor intersection had pipes protruding below the ceiling which ran along the corridor that measure five feet nine inches from the floor.</p> <p>Based on interview, this was acknowledged by the Director of Plant Operations at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>corridors residents are required to use and are not part of corridors for egress from the building. This facility has been granted a waiver for many years and we will once again request the waiver.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>The ceiling heights have been this way for decades and no resident has been adversely affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>The ceiling area cited is in the basement area. This area was built in the 1920's. There is no economically feasible way to raise the ceiling height. The useful life of the building is 2 years.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>We will be requesting a waiver (K 038 Attachment 1).</p> <p>By what date the systemic changes will be completed.</p> <p>September 10, 2016.</p>		

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SS=E Bldg. 01	<p>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 ensure 1 of 3 sprinkler systems were continuously maintained in reliable operating condition. This deficient practice was not in a resident care area but could affect any staff near section four south.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Assistant #1 on 08/11/16 at 09:24 a.m., over 30 ceiling tiles were missing or contained holes on section four south a non-occupied part of the building. The lack of ceiling tiles created a two foot space between the sprinkler heads and the ceiling deck, which could delay the activation of the sprinkler system in event of a fire. Based on interview during observation, the Maintenance Assistant #1 acknowledged over 30 ceiling tiles were missing leveling the sprinkler heads two feet below the ceiling deck. 3.1-19(b)</p>	K 0062	<p><u>K 062 NFPA 101Life Safety Code Standards</u> What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? The ceiling tiles have been replaced (K 062 Attachment 1).No resident had the potential to be affected by the missing ceiling tiles asthe area is not occupied by any residents and securely locked from residentaccess. How other residentshaving the potential to be affect by the same deficient practice will be identifiedand what corrective action(s) will be taken. No resident had the potential to be affected by the missingceiling tiles as the area is not occupied by residents. What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur. 10% of the ceiling tiles will be monitored monthly throughoutthe building to visually check the condition of the ceiling tiles and replaceany necessary (K 062 Attachment 2). How the correctiveaction(s) will</p>	09/10/2016
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K 0066 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the</p>	K 0066	<p>be monitored to ensure the deficient practice will not recur.e., what quality assurance program will be put into place. The Director of Environmental Services, or his designee,will do monthly checks for twelve months on 10% of the ceiling tiles to check thecondition of the ceiling tiles for any damage. By what date the systemic changes will be completed. September10, 2016.</p> <p><u>K 066 NFPA 101Life Safety Code Standards</u></p>	09/10/2016	

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	<p>facility failed to ensure 1 of 2 area where smoking was permitted for staff and residents were maintained. This deficient practice could affect 45 residents in the smoking area and in Friendship Corner in the event of any emergency.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Plant Operations on 08/11/16 between 11:40 p.m. and 11:50 p.m., the following was noted:</p> <p>a.) The resident designated smoking area by the exit of Friendship Corner was provided with four approved containers with a long neck used for cigarette butts. At least 50 cigarette butts were observed in a trash can mixed with flammable materials.</p> <p>b.) Inside the stairwell of Friendship Corner by the resident designated smoking there were four cigarette butts extinguished and laying on the top step. Based on interview, this was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</p>		<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</p> <p>a. All cigarette butts were removed from the groundand placed in a noncombustible ashtray.</p> <p>b. All cigarette butts were removed from the stairwell.</p> <p>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</p> <p>a. All residents who use this area couldpotentially be affected by this practice.</p> <p>b. All residents who use this area couldpotentially be affected by this practice.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</p> <p>a. Allresidents who smoke will be in-serviced regarding the importance of discardingcigarette butts in approved noncombustible containers.</p> <p>b. All residents who smoke will be in-servicedregarding the importance of discarding cigarette butts in approvednoncombustible containers and not taking cigarette butts into the building.Also, a tile was placed along the bottom of the door to</p>	

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K 0143 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (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; and (b) the area that is mechanically ventilated,		prevent cigarette butts from being thrown under the door frame. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. The Director of Environmental Services, or his designee, will monitor the area weekly to ensure there are no cigarette butts on the ground. The results of this monitoring will be reviewed at QAPI for compliance (K 066 Attachment 1). b. The Director of Environmental Services, or his designee, will monitor the area weekly to ensure there are no cigarette butts in the stairwell. The results of this monitoring will be reviewed at QAPI for compliance (K 066 Attachment 2). By what date the systemic changes will be completed. September 10, 2016.		

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	<p>sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 3 of 3 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice affect all residents on the first, second, and third floors.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations on 08/11/16 from 10:15 p.m. to 12:00 p.m., the mechanical ventilation system was not working were transferring of oxygen took place in the oxygen storage room by the nurse stations on the first, second, and third floors. Based on an interview at the time of observation, the Director of Plant Operations confirmed all three oxygen room mechanical vent were not working.</p> <p>3.1-19(b)</p>	K 0143	<p><u>K 143 NFPA 101Life Safety Code Standards</u> What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? The mechanical vent was repaired during the survey processand is working currently. How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken. All residents living in the affected area have the potentialto be affected by this practice. What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur. The mechanical vent for the oxygen room will be monitoredweekly for six months and monthly thereafter to ensure proper ventilation (K0143 Attachment 1). How the correctiveaction(s) will be monitored to ensure the</p>	09/10/2016

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			<p>deficient practice will not recur.i.e., what quality assurance program will be put into place.</p> <p>The Director of Environmental Services, or his designee, will monitor the mechanical vent weekly for six months and monthly thereafter to ensure proper ventilation. This log will be reviewed in the QAPI meeting to ensure compliance.</p> <p>By what date the systemic changes will be completed. September 10, 2016.</p>		