

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
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NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947
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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
K020000	<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: 12/09/14</p> <p>Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Camelot Care 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 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, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 58 at</p>	K020000	<p>Submission of the Plan of Correction does not constitute an admission of agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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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K020062 SS=F	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/12/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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, record review and interview, the facility failed to ensure 2 of 2 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient</p>	K020062	<p>1. No residents were affected. 2. All residents have the potential to be affected. On December 9th Maintenance Supervisor contacted Logansport Municipal Utilities and received documentation proving 2 Of 2 fire hydrants were continuously maintained, in reliable operating condition and inspected and tested. Last inspection was completed on May 14, 2014. This documentation will be maintained on file at the facility. 3. Preventative maintenance check list has been updated to include retrieving proper paperwork from</p>	12/09/2014

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	<p>practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observations on 12/09/14 during the tour between 1:30 p.m. and 2:30 p.m. with the Maintenance Supervisor, there were two fire hydrants located outside the Maintenance office and the South exit. Based on review of Fire Systems report on 12/09/14 at 3:00 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for the private fire hydrants. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed the fire hydrants were private and documentation of annual fire hydrant inspections were not available for review and the facility was unaware the fire hydrant needed to be serviced annually.</p> <p>3.1-19(b)</p>		Logansport Municipal Utilities regarding fire hydrants. 4. Maintenance supervisor and administrator will meet quarterly to ensure all paperwork needed is on file at the facility. This monitoring will be ongoing.				
K020130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors</p>	K020130	1. No residents were affected. 2. All resident's have the potential to be affected. Maintenance Supervisor contacted Brenneco	01/08/2015			

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	<p>were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 6 residents observed in the Main dining room adjacent to the Kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 12/09/14 at 2:18 p.m. with the Maintenance Supervisor, there was a metal rolling fire door protecting the opening from the kitchen to the Main dining room which lacked an attached inspection tag indicating when the last inspection was done. Based on interview on 12/09/14 at 3:37 p.m. with the Maintenance Supervisor and Inspection vendor there was no additional documentation of an annual inspection or test to check for proper operation and full closure.</p> <p>3.1-19(b)</p>		<p>whom we contract to inspect our sprinkler system to ensure the metal rolling door is inspected. This inspection will be completed by January 8th, 2015. 3. Brenneco has added the inspection of the metal rolling door to their sprinkler inspection to be completed annually. 4. Maintenance Supervisor and administrator will meet quarterly to ensure all inspections are completed and paper work is on file at the facility. This monitoring will be ongoing.</p>	

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

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