

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2014
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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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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: 05/22/14</p> <p>Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Warsaw Meadows 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 III (211) construction in the original building and Type V (111) construction in the northwest, west and laundry wings and all were fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K010000		

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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K010025 SS=D	<p>corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 66 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage providing storage for the mowers and maintenance supplies, a shed with activity supplies, and a storage pod with wheelchairs, beds and walkers.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/27/14.</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 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</p>						

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	<p>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 Maintenance Director on 05/22/14 at 1:28 p.m., expandable foam was used to seal the ceiling penetration around a large cluster of IT cables in the closet of the Business Office. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K010025	<p>1. There was an open area in a ceiling smoke barricade around electronics wiring in the Business Office. Maintenance Director removed old fire caulk and replaced it with intumescent sealant in it's entirety.2. No other areas had an issue.3. Any renovations or work done that effects smoke barriers will be reviewed by Regional Director of Plant Operations before finished.4. Administrator will sign off on any work completed/renovations to verify smoke barricades are completely sealed.5. Completion Date: 6/2/14</p>	06/02/2014

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the monthly fire drill documentation titled "Facility WMCC" with the Maintenance Director on 05/22/14 at 11:38 p.m., the third shift fire drills were not actual drills but decisions and review sessions. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>1. Fire drills were completed as a verbal understanding of alarms and procedures on midnight shift instead of an actual drill. Fire drills will be completed in the same manner for all shifts which include setting off alarm, overheading Alarm Red and area of alarm, responding to fire area and ensuring residents are behind smoke doors out of that area, working with Fire Department for quick notification and response to fire. Drills will be completed when scheduled as required by State and Federal guidelines.2. No other shifts had an issue as fire drills were completed correctly.3. All staff involved in fire drills will sign off on the drill forms that they successfully completed the drill. Fire safety and procedures will be retrained to all staff during mandatory All Staff Meeting on 6/9/14.4. Administrator will review drills with Maintenance</p>	06/09/2014

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			Director monthly and issues will be addressed in monthly Process Improvement Meeting until 100% of staff have successfully completed a fire drill.5. Completion date: 6/9/14		