

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155551	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/10/2015
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NAME OF PROVIDER OR SUPPLIER  ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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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: 09/10/15</p> <p>Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950</p> <p>At this Life Safety Code survey, Rolling Meadows Health 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 III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wire smoke detection in the resident rooms, corridors and areas open to the corridors. The facility has a capacity of 115 and had a census of 86 at the time of this survey.</p>	K 0000		

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 0021 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. The facility had three detached sheds providing facility services including the maintenance supplies, activity supplies and wheel chairs that were not sprinklered.</p> <p>Quality Review completed 09/15/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to the kitchen was equipped with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice can affect 60 residents using the dining room and staff in the kitchen.</p> <p>Findings include:</p>	K 0021	<p><b>Corrective Actions:</b> No residents were negatively affected. The door to the kitchen through the environmental office from the dining room now has a self-closing unit.</p> <p><b>Identification of corrective actions taken for other residents having the potential to be affected by the alleged practice:</b> All residents in the facility have the potential to be</p>	10/10/2015

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K 0025 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Maintenance Director and Administrator on 09/10/15 at 10:35 a.m., the door to the kitchen through the Environmental office from the dining room which was open to the corridor; latched into the frame but was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the door was not equipped with a self closer.</p> <p>3.1-19(b)</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</p>		<p>affected. All other doors that would require a self-closing unit have been inspected with no further issues. The door to the kitchen through the environmental office from the dining room is now working properly.</p> <p><b>Measures taken to and systematic changes made to ensure that the alleged deficient practice does not reoccur:</b> All doors that have and require a self-closing unit have been inspected and are in proper working condition. Maintenance director and assistant have updated the facility TELS system.</p> <p><b>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not re occur:</b> The maintenance director or designee will inspect all doors within the facility on a weekly basis and document findings. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring.</p> <p><b>Corrective actions Completed:</b> All corrections were completed before October 10, 2015</p>		

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	<p>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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 43 residents in two of six smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Maintenance Director on 09/10/15 12:05 p.m., the following smoke barrier walls had unsealed</p>	K 0025	<p><b>Corrective Actions:</b> No residents were negatively affected. The 3 unsealed areas in the smoke barrier and the expandable foam in the attic above Loretta lane were removed and sealed correctly. The area on the ceiling of room 313 was sealed correctly as well.</p> <p><b>Identification of corrective actions taken for other residents having the potential to be affected by the alleged practice:</b> All residents in the mentioned smoke barriers have the potential to be affected. All smoke barriers in the facility have been inspected for penetrations that do not have the proper fire rated material.</p> <p><b>Measures taken to and systematic changes made to ensure that the alleged deficient practice does not reoccur:</b> All smoke barriers in the facility have been inspected for penetrations that do not have the proper fire rated material. All expandable foam has been removed and approved fire rated material has been applied.</p> <p><b>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice</b></p>	10/10/2015

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	<p>penetrations or penetrations sealed with an un-rated material:</p> <p>a) in the attic of the Loretta Lane smoke barrier wall there were 3 unsealed one fourth of an inch penetrations around wires.</p> <p>b) in the attic of the Loretta Lane smoke barrier wall there was expandable foam which was not fire rated used to seal group of wires through the smoke barrier wall.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations. Also, the Maintenance Director did not know if the expandable foam was an approved material and did not have the documentation to show if the foam met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were 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 could affect 26 residents in one of 1 of 6 smoke compartments.</p>		<p><b>does not re occur:</b> The maintenance director or designee have completed a facility wide inspection of smoke barriers. No other penetrations in smoke barriers were found to be deficient. All foregoing penetrations in smoke barriers will be sealed with the approved fire rated material. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring</p> <p><b>Corrective actions Completed:</b> All corrections were completed before October 10, 2015</p>	

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K 0029 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director and Administrator on 09/10/15 at 11:11 a.m., in the ceiling of room 313 there was an unsealed one fourth of an inch penetration around a conduit . Based on interview at the time of observation, the Maintenance Director acknowledged and provided the Measurements of the penetration.</p> <p>3.1-19(b)</p> <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 3 of 9 hazardous areas, such as a boiler room or soiled linen storage room was smoke resistive. This deficient practice could affect 60 residents in three of six smoke</p>	K 0029	<p><b>Corrective Actions:</b> No residents were negatively affected. The 5 unsealed areas in the smoke barrier and the expandable foam in the sprinkler riser room, housekeeping closet on Oak Lane, and the Mechanical room on Birch Lane, were removed and</p>	10/10/2015

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	<p>compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and Administrator on 09/10/15 between 10:00 a.m. and 12:00 p.m., the following hazardous areas had unsealed penetrations or penetrations sealed with an un-rated material:</p> <ol style="list-style-type: none"> <li>1. in the Sprinkler Riser room, which contained two hot water heaters, there were six unsealed penetrations measuring a half inch to a fourth inch around conduit, wires, and piping.</li> <li>2. in the Sprinkler Riser room, which contained two hot water heaters, there were four penetrations sealed with white expandable foam with an unknown fire rating.</li> <li>3. in the Housekeeping closet on Oak Lane, which contained soiled linen and trash, there was a penetration sealed with a white expandable foam with an unknown fire rating.</li> <li>4. in the Mechanical room on Birch Lane, which contained a hot water heater, there where four unsealed penetrations measuring a two inches through conduit which contained wires.</li> <li>5. in the Mechanical room on Birch Lane, which contained a hot water heater, there where four penetrations sealed with white</li> </ol>		<p>sealed correctly.</p> <p><b>Identification of corrective actions taken for other residents having the potential to be affected by the alleged practice:</b>All residents in the mentioned smoke barriers have the potential to be affected. All smoke barriers in the facility have been inspected for penetrations that do not have the proper fire rated material.</p> <p><b>Measures taken to and systematic changes made to ensure that the alleged deficient practice does not reoccur:</b> All smoke barriers in the facility have been inspected for penetrations that do not have the proper fire rated material. All expandable foam has been removed and approved fire rated material has been applied.</p> <p><b>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not re occur:</b> The maintenance director or designee have completed a facility wide inspection of smoke barriers. No other penetrations in smoke barriers were found to be deficient. All foregoing penetrations in smoke barriers will be sealed with the approved fire rated material. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring</p>				

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K 0044 SS=E Bldg. 01	<p>expandable foam with an unknown fire rating. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations. Also, the Maintenance Director did not know if the expandable foam was an approved material and did not have the documentation to show if the foam met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 30</p>	K 0044	<p><b>Corrective actions Completed:</b> All corrections were completed before October 10, 2015</p> <p><b>Corrective Actions:</b> No residents were negatively affected. The fire door set on Birch lane has a new closure unit. The fire door set is now latching into the frame. <b>Identification of corrective actions taken for other residents having the potential to be affected by the alleged practice:</b> All residents have the potential to be affected. All fire door sets in the facility have been inspected with no findings. <b>Measures taken to and systematic changes made to ensure that the alleged deficient practice does not</b></p>	10/10/2015

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K 0147 SS=E Bldg. 01	<p>residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 09/10/15 at 10:35 a.m., the fire door set by the Birch Lane nurses' station failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed these were fire doors by the Maintenance Director and the Administrator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute</p>	K 0147	<p><b>reoccur:</b> All fire doors in the facility have been inspected and tested to latch properly into the door frame. Maintenance director and assistant have updated the facility TELS system. <b>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not re occur:</b> The maintenance director or designee will inspect all fire doors within the facility on a weekly basis and document findings. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring <b>Corrective actions Completed:</b> All corrections were completed before October 10, 2015</p> <p><b>Corrective Actions:</b> No residents were negatively affected. The extension cord that was providing power has been removed. <b>Identification of corrective actions taken for other residents having the potential to be affected by the alleged practice:</b> All residents have the potential to be affected. All sources of electricity in the attics have been visually inspected.</p>	10/10/2015			

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	<p>for fixed wiring of a structure. This deficient practice could affect 20 residents in one of five smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 09/10/15 at 12:10 p.m., the following was noted:</p> <ol style="list-style-type: none"> <li>1. a regular weight extension cord was providing power to a power strip and another regular weight extension was plugged into that power strip providing power for cable television equipment in the attic above Birch and Loretta Lanes.</li> <li>2. there were two regular weight extension cords plugged into a power strip providing power for cable television equipment in the attic above Birch and Loretta Lanes.</li> </ol> <p>Based on interview, this was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>		<p><b>Measures taken to and systematic changes made to ensure that the alleged deficient practice does not reoccur:</b> All sources of electricity in the attics have been visually inspected. Maintenance director and designee have been inserviced on the proper usage of electrical cords in health care facilities.</p> <p><b>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not re occur:</b> The maintenance director or designee will inspect all sources of electricity on a weekly basis. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring</p> <p><b>Corrective actions Completed:</b> All corrections were completed before October 10, 2015</p>		