

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
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: 1/21/15</p> <p>Facility Number: 001215 Provider Number: 155796 AIM Number: 100450890</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist; Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Cedars 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) and 410 IAC 16.2. The original section of the building consisting of the 300 hall, 400 hall and the main dining area was surveyed with Chapter 19, Existing Health Care Occupancies</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
K010029 SS=E	<p>The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 65 and had a census of 56 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. The facility does have a barn providing facility services that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/28/15.</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 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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	
K010050 SS=C	<p>Based on observation and interview, the facility failed to ensure 2 of 2 kitchen doors close and latched into the door frame. This deficient practice could affect all residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/21/14 at 1:24 p.m., both doors going in and out of the kitchen from the dinning room did not latch into the door frame. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <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</p>	K010029	<p>Moss Engineering will install panic push devices on both inbound and outbound doors at the kitchen. To insure nightly safety for the kitchen and our residents, the inbound door will be locked with a dead bolt. A warning label stating "these doors will remain unlocked during business hours" will be posted on the door. The kitchen Supervisor will monitor the latching of the doors throughout the day. These door latches will be installed before 2-20-15. Revised POC On 2-18-15, Moss Engineering will install a push operated latching device on the outbound door and a lever latch on the inbound door to the kitchen. The dead bolts will be removed at the same time.</p>	02/18/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	
	<p>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>1. Based on record review and interview, the facility failed to conduct quarterly fire drills for second shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the " Fire Drill Report" forms with the Maintenance Director on 01/21/15 between 11:13 a.m. and 11:53 a.m., all second shift fire drills took place between 3:35 p.m. and 4:55 p.m. for the last four quarters. This was confirmed by the Maintenance Director at the time of record review.</p> <p>2. Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal to monitoring company for 8 of 12 fire drills conducted. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p>	K010050	<p>Fire drills will be conducted no less than two hours after the last fire drill for that shift. A column will be added to acknowledge transmission of the fire alarm to the monitoring company. This action will be overseen by the Maintenance Director each month. This will be completed by 2-20-15.</p>	02/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	
K010056 SS=C	<p>Based on record review of the " Fire Drill Report" forms with the Maintenance Director on 01/21/15 between 11:13 a.m. and 11:53 a.m., the documentation for eight of the twelve fire drills conducted between the hours of 6am and 9pm lacked the verification fire alarm signal to monitoring company. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the</p>	K010056	On 1-22-15, Koorsen Fire and Security removed the sprinkler	01/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
K010061 SS=C	<p>facility failed to ensure 2 of 2 sprinkler heads in the Main Dinning room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the dinning room in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 01/21/15 at 3:00 p.m., the main dinning room had two sprinkler heads located three feet apart. The measurement was given and acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 sprinkler system water valves to ensure they were properly electrically supervised. This deficient practice affects all occupants.</p>	K010061	<p>head from the dining room. In any future renovation, the Director of Maintenance will ensure no new sprinklers are installed no closer than 6 feet of existing sprinkler heads.</p> <p>Koorsen Fire and Security Inspection Report indicated that the main panel was not alarming during the test. On 2-11-15, Nowak Supply Company will be at The Cedars to rework the alert panel to notify the monitoring company when the pump valve is</p>	02/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	
K010147 SS=A	<p>Findings include:</p> <p>Based on observation and records review with the Maintenance Director on 1/21/15 at 11:30 p.m., the water shut off valves in the sprinkler riser room were not electronically supervised properly. According to the "Sprinkler Inspection Report" dated 5/20/14, the inspection form stated that the control valves supervisory devices were not working properly. Based on an interview with the Maintenance Director, there was no paper work showing the correction of the problem and the Maintenance Director did not know if any repairs were done to the devices.</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 2 of 2 flexible cords such as an extension cord was not used as a substitute for fixed wiring for high draw equipment. 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</p>	K010147	<p>open. The Maintenance Director will check quarterly inspections with Koorsen Fire and Security to insure it is monitoring correctly.</p> <p>The extension cord in the Executive Director's office will be removed and a refrigerator will be repositioned to be plugged directly into the wall outlet. This will occur before 2-20-15. Housekeeping staff will be advised to alert Director of Maintenance on any Office electrical issues they have in question. The Director of Maintenance will add routine</p>	02/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	
K010160 SS=F	<p>permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. 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 12/21/15 at 12:35 p.m., A regular heavy weight extension cord was providing power for computer equipment and an extension cord power strip was providing power to a refrigerator in the administrator's office. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation, record review and interview; the facility failed to ensure 2 of 2 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage.</p>	K010160	<p>checks for new appliances in offices.</p> <p>TAG K160 does not pertain to our Facility due to the fact we are a one (1) story facility with a basement with an elevator travel distance of 12 feet. The Life Safety Code standard calls for a</p>	03/06/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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>NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/21/15 at 12:13 p.m., the elevator equipment room was provided with a sprinkler and a smoke detector. Based on interview at the time of observation, the Maintenance Supervisor acknowledged it was unknown if a shunt trip for the elevator equipment room sprinkler was provided.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by</p>	K020000	<p>travel distance of 25 feet or more. Revised POC The elevator machine rooms will be regulated with a shunt trip breaker. Nowak Supply will provide the smoke and heat detector relays for the elevator company on 2-20-15. ThyssenKrupp, our elevator company, will wire the smoke detector to send the elevator to the bottom floor and open when activated and the heat sensor will trip the shunt breaker when activated. This will be completed by 3-6-15.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
	<p>the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/21/15</p> <p>Facility Number: 001215 Provider Number: 155796 AIM Number: 100450890</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist; Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Cedars 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) and 410 IAC 16.2. The new section of the building consisting of the extension of the 200 hall was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a basement 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 hard wired smoke detectors in the resident rooms. The facility has a capacity of 65 and had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
K020050 SS=C	<p>a census of 56 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. The facility does have a barn providing facility services that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/28/15.</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 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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct quarterly fire drills for second shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p>	K020050	Fire drills will be conducted no less than two hours after the last fire drill for that shift. A column will be added to acknowledge transmission of the fire alarm to the monitoring company. This	02/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015	
NAME OF PROVIDER OR SUPPLIER CEDARS THE				STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765			
(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			
	<p>Findings include:</p> <p>Based on record review of the " Fire Drill Report" forms with the Maintenance Director on 01/21/15 between 11:13 a.m. and 11:53 a.m., all second shift fire drills took place between 3:35 p.m. and 4:55 p.m. for the last four quarters. This was confirmed by the Maintenance Director at the time of record review.</p> <p>2. Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal to monitoring company for 8 of 12 fire drills conducted. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review of the " Fire Drill Report" forms with the Maintenance Director on 01/21/15 between 11:13 a.m. and 11:53 a.m., the documentation for eight of the twelve fire drills conducted between the hours of 6am and 9pm lacked the verification fire alarm signal to monitoring company. This was confirmed by the Maintenance Director at the time of record review.</p>		<p>action will be overseen by the Maintenance Director each month. This will be completed by 2-20-15.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
--	--

(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
K020061 SS=C	<p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on observation and interview, the facility failed to maintain 2 of 2 sprinkler system water valves to ensure they were properly electrically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation and records review with the Maintenance Director on 1/21/15 at 11:30 p.m., the water shut off valves in the sprinkler riser room were not electronically supervised properly. According to the "Sprinkler Inspection Report" dated 5/20/14, the inspection form stated that the control valves supervisory devices were not working properly. Based on an interview with the Maintenance Director, there was no paper work showing the correction of the problem and the Maintenance Director did not know if any repairs were done to the devices.</p> <p>3.1-19(b)</p>	K020061	<p>Koorsen Fire and Security Inspection Report indicated that the main panel was not alarming during the test. On 2-11-15, Nowak Supply Company will be at The Cedars to rework the alert panel to notify the monitoring company when the pump valve is open. The Maintenance Director will check quarterly inspections with Koorsen Fire and Security to insure it is monitoring correctly.</p>	02/11/2015

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

PRINTED: 02/19/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER CEDARS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765		
(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	