

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2014
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NAME OF PROVIDER OR SUPPLIER  RENAISSANCE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814
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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: 12/15/14</p> <p>Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Renaissance Village was found in not 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, areas open to the corridor and hard wired smoke detectors in resident</p>	K010000		
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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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K010018 SS=E	<p>rooms 310-317. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 96 and had a census of 56 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 which the exception of a detached garage used to store maintenance supplies and equipment.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/23/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are</p>			

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	<p>permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 3 of 16 200 hall resident rooms ' corridor doors. This deficient practice could affect 14 of 14 residents.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 12/15/14 between 11:40 a.m. and 11:55 a.m., the corridor doors to rooms 212, 208, 206 in the 200 hall were obstructed by the restrooms door preventing the doors from closing and latching into the door frame. This was acknowledged by the Environmental Supervisor at the time of observations. He also stated that all rooms in the 200 hall were arranged so that the rest room doors could obstruct the closing of the corridor doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 16 resident room corridor doors on the 200 hall closed and latched into the door frame. This deficient practice could affect any of the 2 of 14 residents on the west</p>	K010018	<p><u>CORRECTIVE ACTION:</u> Installed spring loaded hinges to bathroom doors</p> <p><u>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS:</u> Inspected and installed spring loaded hinges on 208, 206, and 210 bathroom doors to swing doors to closed position</p> <p><u>MEASURES FOR PREVENTION:</u> Installed spring loaded hinges on remaining bathroom doors in facility. Daily Checks being performed to ensure bathroom doors are remaining in the closed position <u>QA FOR PREVENTION:</u> Quality Assurance (QA) includes monitoring of daily checklists being completed, review on monthly maintenance checklist and reviewed at monthly / quarterly interdisciplinary QA meeting <u>CORRECTIVE ACTION:</u> Adjusted the door latch on 210 to ensure proper latching (See Attachment B)</p> <p><u>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS:</u> All doors were checked to make sure they latch properly <u>MEASURES FOR PREVENTION:</u> Daily Checks are being performed to ensure that all doors closing with proper latch and catch <u>QA FOR</u></p>	12/27/2014

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K010029 SS=E	<p>hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 12/15/14 at 11:50 a.m., the corridor door to resident room 210 failed to latch into the door frame. This was acknowledged by the Environmental Supervisor at the time of observations.</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 2 of 4 ceiling penetrations in a hazardous area such a furnace room was maintained to be</p>	K010029	<p><u>PREVENTION:</u> Quality assurance includes monthly monitoring of checklist completion, which is then reviewed at monthly and quarterly interdisciplinary QA meeting</p> <p><u>CORRECTIVE ACTION:</u> Fire caulk installed in two ceiling penetrations for 200 Hall furnace room (See Attachment B)</p> <p><u>IDENTIFICATION/CORRECTIVE</u></p>	12/17/2014

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K010052 SS=F	<p>smoke resistance. This deficient practice could affect 14 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation and interview with the Environmental Supervisor on 12/15/14 at 11:52 a.m., he acknowledged that in the 400 hall mechanical/furnace room there were two unsealed penetrations ranging in size from one fourth inch to three fourth inch. Measurements were provided by the Environmental Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72 the National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms,</p>	K010052	<p><u>ACTION FOR POTENTIALLY AFFECTED RESIDENTS:</u> Inspected remaining furnace rooms <u>MEASURES FOR PREVENTION:</u> Daily Checks of furnace rooms added to checklist to ensure no ceiling penetrations. <u>QA FOR PREVENTION:</u> Quality Assurance (QA) includes monitoring of daily checklists being completed, review on monthly maintenance checklist and reviewed at monthly/quarterly interdisciplinary QA meeting</p> <p><u>CORRECTIVE ACTION:</u> Alarm has 24 hour monitoring oversight. Working with vendor to increase volume at the nurses station. In-service Staff on alarms and manner in which to address them (See Attachment A) <u>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS:</u></p>	01/02/2015			

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	<p>supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 12/15/14 at 1:16 p.m., the main fire alarm panel is located inside an electrical/mechanical room located across from the nurses' station preventing the trouble signal from being clearly heard by staff. Based on an interview at the time of observation, the Lead Shift Registered Nurse (RN) when asked if the trouble alarm on the fire panel could be heard, the RN stated that it was very faint and difficult to clearly hear. When asked what the alarm meant, the RN did not know or what to do when the trouble alarm sounds.</p>		<p>Review and update current policy and procedure. (See Attachment A) In-service Staff and review. Continue with 24 hour oversight monitoring with facility notification at trouble alarm. <u>MEASURES FOR PREVENTION:</u> Add this policy to annual Fire and Safety In-Service <u>QA FOR PREVENTION:</u> Quality Assurance (QA) includes monitoring of daily checklists being completed, review on monthly maintenance checklist and reviewed at monthly / quarterly interdisciplinary QA meeting</p>	