

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN 46580
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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
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K010000	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/24/14</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mason 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 300 halls and the center hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors</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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K010025 SS=E	<p>and hard wired smoke detectors in the resident rooms. The facility has a capacity of 110 and had a census of 77 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including the storage of activity supplies, maintenance supplies and housekeeping supplies which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/29/14.</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 on each floor. Dampers are not required in duct penetrations of smoke barriers in fully</p>			
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	<p>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 observation with the Maintenance Supervisor on 07/24/14 at 12:50 p.m., there was a ceiling penetration that was sealed with expandable foam and another that was unsealed measuring one and one half inch around telephone lines in the Maintenance office closet. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010025	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law.</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating.</p> <p>Facility failed to ensure ceiling smoke barrier were maintained to provide a one half hour fire resistance rating. A ceiling penetration was sealed with expandable foam and another was unsealed measuring one and one half inch around telephone lines in the Maintenance office closet.</p> <p>Maintenance will remove all expandable foam from the opening and seal all openings identified with proper Fire Caulking. This is to be completed by 8/15/2014.</p> <p>Maintenance will complete a walk-thru of all areas for any other penetrations that have not been sealed and properly seal all openings with Fire Caulk. Maintenance will follow-up with all outside contractors performing</p>	08/15/2014	

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K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen K-Class fire extinguishers was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice was not in a resident care area but could affect facility kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 07/24/14 at 12:58 a.m., the gauge on the K-Class portable fire extinguisher in the kitchen</p>	K010064	<p>work in the facility to ensure all openings made by the contractors have been properly sealed. Maintenance will make an inspection of penetration areas while performing the any TELS Audits and record any findings. The Administrator will follow-up with maintenance by reviewing the TELS Audit reports on a monthly basis.</p> <p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law.</p> <p>1. The K-fire extinguisher was ordered and delivered same day noted to be empty. A complete building audit was done. No other extinguishers were found to be out of compliance. 1a. Location was not in a resident area, but could affect staff. 1b. The Maintenance Supervisor will inspect the kitchen fire extinguisher weekly to ensure it is maintaining its charge for 1 month, then monthly checks. 1c. Results of the weekly inspections will be presented to the Quality Assurance Committee monthly.</p>	07/24/2014	

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K010143 SS=E	<p>indicated it needed to be recharged. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect 1 of 6</p>	K010143	<p>Then monthly inspections will be presented to the Quality Assurance Committee for three months, then quarterly after that. 1d. Corrections completed by 7/24/2014.</p> <p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that</p>	08/05/2014	

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K020000	<p>smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 07/23/14 at 1:05 p.m., the mechanical ventilation in the service hall oxygen transfilling/storage room which contained at least three large stationary containers of liquid oxygen was not working. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/24/14</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p>	K020000	<p>one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law.1. The mechanical ventilation in the service hall oxygen transfilling/storage room has been fixed. A complete building audit was done. No other issues were found. 1a. Location was not in a resident area, but could affect staff. 1b. The Maintenance Supervisor will inspect the mechanical ventilation monthly to ensure it is in proper working condition. 1c. Results of the monthly inspections will be documented and then presented to the Quality Assurance Committee monthly. 1d. Corrections completed by 8/5/2014.</p>				

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	<p>At this Life Safety Code survey, Mason 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) and 410 IAC 16.2. The 2004 addition of the 400 Hall and the Therapy room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 110 and had a census of 77 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including activity supplies, maintenance supplies and housekeeping supplies that were not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</p>						

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

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