STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155631	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER WHITE RIVER LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 3710 KENNY SIMPSON LN BEDFORD, IN 47421	

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K010000	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). Survey Date: 11/20/14 Facility Number: 001153 Provider Number: 155631 AIM Number: 200155900 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, White River Lodge 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. 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 hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 74	K010000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by then Federal and State law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 12/20/2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and had a census of 46 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010021 SS=E	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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 10 hazardous area room doors, such as a kitchen door was only held open by a device which	K010021	K 021 The facility does ensure any door in	12/20/2014

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	would allow the door to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect any number of residents, as well as staff and visitors while in the main dining room. Findings include: Based on observation on 11/20/14 at 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, the door between the kitchen dishwashing room and the main dining room was equipped with a self closer, however, the door was held wide open with a wooden door wedge which would not allow the door to close upon activation of the fire alarm system. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close upon activation of fire alarm system. The identified wooden wedge was removed immediately 11/20/14 when observed and the staff person placing it was counseled for failure to follow facility policy. All staff were reeducated and all new staff on hire will be educated on the facility policy prohibiting propping open of doors with a wedge or other device. The maintenance supervisor or designee will audit the doors in the facility 7 random times per week for one month (across all shifts and weekends) and then weekly for 6 months and report negative findings to facility QAPI committee. Further audits will be continued based on any negative findings.	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit egress for 1	K010038	K038	12/20/2014

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	of 7 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires that walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect up to 19 residents, as well as staff and visitor in the 300 hall. Findings include: Based on observation on 11/20/14 at 12:00 p.m. during a tour of the facility with Maintenance Supervisor, the side walk outside the 300 hall exit had a one inch grade change where the first large section of concrete met the sidewalk, which could create a tripping hazard. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the one inch grade change where the first large section of concrete met the sidewalk could be a tripping hazard. 3.1-19(b)		The facility does ensure exit access is arranged so that exits are readily accessible at all times. Facility administration had already identified grade change due to freezing/thawing of concrete at 300 hall exit and repairs were already being initiated. A ramp that will be secured to walk reducing tripping hazard and recurrence of identified issue will be in place on or before 12/20/14. Facility maintenance supervisor and administrator make regular walking rounds through facility and about grounds to identify potential hazards and this continues. The maintenance supervisor will audit exits monthly to ensure no further grade changes or tripping hazards are identified to exit access for 6 months and report negative findings to facility QAPI committee. Further audits will continue based on negative findings.	

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K010050 SS=F	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 Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 12 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 11/20/14 at 10:00 a.m. with the Maintenance Supervisor present, the fire drill form the facility uses has the question "The fire alarm was received by monitoring company or fire department". There was only an answer on four of the twelve fire drills performed during the	K010050	K050 The facility does hold fire drills at unexpected times under varying conditions at least quarterly on each shift to ensure staff are familiar with procedures. The Maintenance Director has been reeducated on the Fire Drill procedure and documentation requirements. The facility has conducted a fire drill since surveyor exited facility and has documentation of monitoring company receiving the transmission and documentation of person completing the document. Maintenance supervisor will ensure that the Alarm System Company transmission success information is provided post each fire drill process and documented. The facility administrator will audit all fire drills for completed documentation including transmission of fire alarm to	12/20/2014

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	past 12 months, furthermore, the only answer on two of the drills was the time the alarm was received by the monitoring company, and a check mark on the other two. There was no further information on the fire drills, such as, the name of the person spoken to at the monitoring company and the time the transmission of the fire alarm was received for the rest of the fire drills. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation for the transmission of the fire alarm to the monitoring company was not complete information. 3-1.19(b)		monitoring company monthly for 6 months and report negative findings to facility QAPI. Further audits will continue based on the negative findings.	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions	K010062	K062 The facility does assure that sprinkler systems are in place and functioning to assure the safety of all residents and staff in the facility. The facility does have required automatic sprinkler systems continuously maintained in reliable operating condition and they are	12/20/2014

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	where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of sprinkler system inspection reports on 11/20/14 at 10:15 a.m. with the Maintenance Supervisor present, there was no documentation to show the sprinkler system had ever had an internal pipe inspection. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the sprinkler system has never had an internal pipe inspection. 3-1.19(b)		inspected with preventative maintenance and repairs if needed by the fire safety company. Facility did contact The Fire Safety Company to complete inspection of internal pipes as indicated need in survey and this was completed on 12/5/14 with no obstructions or concerns identified. The facility will continue to have the fire company review all systems regularly and maintain those inspection reports for review by the survey teams. The maintenance supervisor will monitor inspection timeline completions and report any negative findings monthly to facility QAPI.	
K010069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998	K010069	K069 The facility does assure that cooking facilities are protected. The facility	12/20/2014

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	Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect mostly kitchen staff, plus any resident while in the adjacent dining room. Findings include: Based on review of the kitchen range inspection reports in the Life Safety Reports book on 11/20/14 at 10:30 a.m.		fire safety company has inspected range hood at intervals in past with no identified concern but documentation failed to reflect areas inspected and results of inspection. Facility contacted certified company to complete inspection of entire exhaust system and they are scheduled to complete on or before 12/20/14 with subsequent follow up semiannually and as needed. The maintenance supervisor will submit required reports to the Administrator and the Administrator will report negative findings to the QAPI Committee for 12 months.	

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	with the Maintenance Supervisor present, there was no documentation available to show the kitchen range hood had been inspected semiannually during the past twelve months. This was acknowledged by the Maintenance Supervisor at the time of record review. 3.1-19(b)			