

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2015
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NAME OF PROVIDER OR SUPPLIER BLAIR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970
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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: 09/22/15</p> <p>Facility Number: 012565 Provider Number: 155791 AIM Number: 201021970</p> <p>At this Life Safety Code survey, Blair Ridge Health Campus 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 18, New 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, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 53 at the time of this survey.</p>	K 0000	<p>F000</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Survey on September 22, 2015. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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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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K 0021 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 09/23/15 - 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. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation an interview, the facility failed to ensure 1 of 1 doors entering the kitchen open to the corridor would latch into the door frame. This deficient practice could affect at least 10 residents using the facility's dining room and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0021	<p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The closer for the door entering the kitchen has been adjusted by Plant Ops staff to allow the door to fully latch into the door frame.</p>	10/21/2015

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	<p>facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 10:05 a.m., the door entering the kitchen from the dining room was a self closing door and equipped with an automatic latch but failed to automatically latch into the door frame. Based on interview at the time of observation, this was acknowledged by the Director of Plant Services and the Environmental Services Director.</p> <p>3.1-19(b)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents residing on the Health Center are potentially affected by the alleged deficient practice. The door entering the kitchen has had the closer adjusted by Plant Ops staff to allow the door to fully latch into the door frame.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>Fire Barrier doors will be placed onto a weekly check list by plant ops staff to be audited for proper closing and adjustments to closers as needed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality</p>		

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K 0027 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke/fire barrier doors were equipped with rabbets, bevels, or astragals at the meeting edges. This deficient practice affects 9 residents on the 300 hall.</p>	K 0027	<p>assurance program will be put into place:</p> <p>Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The smoke/fire barrier doors</p>	10/21/2015

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 11:00 a.m., the smoke/fire door set separating the health care center from the assisted living center was not equipped with rabbets, bevels, or astragals at the meeting edges of the doors. Based on interview during at the time of observation, the Director of Plant Services and the Environmental Services Director acknowledged that the smoke/fire door set was not equipped with rabbets, bevels, or astragals at the meeting edges of the door.</p> <p>3.1-19(b)</p>		<p>on 300 hall will have metal installed at the meeting edges to ensure a proper fire/smoke barrier at this opening.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents residing on the 300 hall are potentially affected by the alleged deficient practice. The smoke/fire barrier doors on 300 hall will have metal installed at the meeting edges to ensure a proper fire/smoke barrier at this opening.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>Fire Barrier doors will be placed onto a weekly check list by plant ops staff to be audited for proper barrier closure.</p>		

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure penetrations in a hazardous area was maintained to provide a one hour fire resistance rating. This deficient practice could affect up to 10 residents in 1 of 5 smoke compartments.</p>	K 0029	<p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The ceiling penetrations have been repaired with caulking</p>	10/21/2015

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 10:05 a.m., in the ceiling of the maintenance room, which contained a hot water heater, there were nine penetrations around electric conduit sealed with a white caulk. Based on interview at the time of observation the, the Director of Plant Services did know or have documentation to show if the white caulk meets the requirements for use in through penetration fire stop systems for health care facilities.</p> <p>3.1-19(b)</p>		<p>meeting the requirements in the mechanical room off the service hallway.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>No residents reside on the service hallway. The ceiling penetrations have been repaired with caulking meeting the requirements in the mechanical room off the service hallway.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>The mechanical room penetrations will be placed onto a weekly check list by plant ops staff to be audited for proper caulking meeting the requirements.</p> <p>How the corrective action will be monitored to ensure the</p>		

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K 0038 SS=E Bldg. 01	<p>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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 delayed egress locks in the facility was accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved,</p>	K 0038	<p>deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The magnetic lock for the exit door next to the beauty shop was immediately adjusted by the plant ops director to allow for the automatic release after 15 seconds.</p>	10/21/2015

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	<p>supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect up to 20 residents in 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 10:47 a.m., the exit door located by the beauty shop leading to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>Residents residing on the 300 and 400 halls are potentially affected by the alleged deficient practice. The magnetic lock for the exit door next to the beauty shop was immediately adjusted by the plant ops director to allow for the automatic release after 15 seconds.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>The exit door next to the beauty shop has been placed on a weekly audit check to ensure its proper operation allowing automatic release after 15 seconds of pressure.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not</p>	

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K 0044 SS=E Bldg. 01	<p>pushed with the application of force three separate times. Based on interview at the time of observation, the Director of Plant Services stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and the necessary signage, but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times.</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. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets in the facility was arranged to automatically close and latch. LSC requires 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 positive latching is</p>	K 0044	<p>recur, i.e. what quality assurance program will be put into place:</p> <p>Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: The fire barrier doors leading from the 300 hall to the Assisted Living have been adjusted to ensure automatic latching upon closure / release from the magnetic holders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents on the 300 Hall are potentially affected by the alleged deficient practice. The fire barrier doors leading from the</p>	10/21/2015

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K 0147 SS=B Bldg. 01	<p>achieved on each door operation. This deficient practice affects 9 residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 11:00 a.m., one of the fire doors of the fire door set separating the health care center from the assisted living center did not automatically latch into the frame when tested. Based on interview, this was acknowledged by the Director of Plant Services and the Environmental Services Director at the time of observation.</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 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. LSC 9.1.2 requires electrical wiring and</p>	K 0147	<p>300 hall to the Assisted Living have been adjusted to ensure automatic latching upon closure / release from the magnetic holders. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The Fire Barrier Doors on all Health Center hallways will be placed onto a weekly check list by plant ops staff to be audited for proper closure / latching upon release from the magnetic holders. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p>	10/21/2015	

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	<p>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 for fixed wiring of a structure. This deficient practice could affect 2 residents in room 405.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Plant Services and the Environmental Services Director on 09/22/15 at 10:35 a.m., In room 405, a regular light weight extension cord was plugged in and providing power for a fan, and a second regular light weight extension cord was plugged in and providing power for holiday lights. Based on interview, this was acknowledged by the Director of Plant Services and the Environmental Services Director at the time of observations.</p> <p>3.1-19(b)</p>		<p>The extension cord in use by a resident in room 405 will be removed and appliances plugged into proper receptacles meeting the requirement.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>The two residents residing in room 405 are potentially affected by the alleged deficient practice. The extension cord in use by a resident in room 405 will be removed and appliances plugged into proper receptacles meeting the requirement.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>All resident rooms on the Health Center will be placed onto a weekly check list by</p>	

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			<p>plant ops staff to be audited for the presence of extension cords and their removal if found.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>Audit results will be reported monthly to the QAA committee by the Plant Ops Director. Results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months, then randomly thereafter for further recommendations.</p>		