

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155600	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/30/2015
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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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K 000  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: 03/30/15</p> <p>Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mulberry Health and Rehabilitation 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), 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 with a basement. The facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K 000	Mulberry Health & Retirement Community respectfully requests a desk re-view in lieu of a on site follow up survey.	
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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 029 SS=E Bldg. 01	<p>open to the corridors and battery powered smoke detectors in 59 resident sleeping rooms in the original portion of the facility and hard wired smoke detectors in the other 27 resident rooms. The facility has a capacity of 149 and had a census of 124 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 except for a detached records building which was not sprinklered.</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 Based on observation and interview, the</p>	K 029	No residents were affected by the alleged deficient practice. The	04/30/2015			

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K 038 SS=F Bldg. 01	<p>facility failed to ensure 1 of 2 doors leading to hazardous areas such as the laundry room would self close. This deficiency could affect 36 residents on 100 hall which is adjacent to the laundry room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/30/15 at 1:35 p.m. with the Administrator, the north laundry door which separates the laundry from 100 hall was not equipped with a self closing device on the door. Based on interview on 03/30/15 concurrent with the observation with the Administrator it was acknowledged the aforementioned laundry room door did not self close because of an absence of a self closing device on the door.</p> <p>3.1-19(b)</p> <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. 19.2.1 Based on observation and interview, the facility failed to ensure 12 of 12 exit doors with electromagnetic locks remained unlocked until the fire alarm system was reset. LSC 7.2.1.6.2 (d)</p>	K 038	<p>facility will install a self closing device on the door that leads out of laundry into a back service hallway that is already protected by a closed door, which is protected beyond that by self releasing fire doors before the residents on 100 would be impacted. Once the self closure is installed no further follow up will be necessary.</p> <p>No residents were impacted by the alleged deficient practice. The alarm servicing company has corrected the problem identified. Maintenance supervisor will monitor randomly selected doors during monthly testing of the fire</p>	04/30/2015			

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	<p>requires doors shall automatically unlock and remain unlocked until the fire protective signaling system has been manually reset. This applies to electromagnetic locks on all doors to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 03/30/15 at 4:10 p.m. during a fire alarm test with the Administrator the electromagnetic locks, all exits did not release upon activation of the fire alarm system. Based on interview concurrent with the observations with the Administrator it was acknowledged all exit doors equipped with electromagnetic locks would not unlock when the fire alarm was activated.</p> <p>3.1-19(b)</p>		<p>system to ensure proper release occurs while alarm is activated. Administrator will monitor quarterly for compliance.</p>	

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K 050 SS=F Bldg. 01	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 03/30/15 at 3:14 p.m. with the Administrator, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months, from 01/2014 to 01/2015</p>	K 050	<p>No residents were affected by the alleged deficient practice. Maintenance supervisor will continue to validate proper alarm transmission to the monitoring station during the monthly tests. This verification will be documented on the alarm testing log with the completion of each fire drill. Administrator will monitor quarterly for compliance.</p>	04/30/2015	

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K 056 SS=E Bldg. 01	<p>indicated the fire alarm system had been activated, but the verification of the transmission of the signal was not documented. Based on interview concurrent with record review it was acknowledged by the Administrator none of the fire drill reports documented the transmission of the signal was received by the monitoring station.</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</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems.</p>	K 056	No residents were affected by the alleged deficient practice. The current lay out of the sprinkler heads identified in the survey actually provide greater coverage	04/30/2015

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K 144 SS=F Bldg. 01	<p>NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers ", states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 5 residents observed in 200 hall dining room, 3 residents observed in 300 hall dining room and 36 residents on 100 hall which is adjacent to the oxygen transfill room on Service hall as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observations on 03/30/15 during the tour between 1:59 p.m. to 2:50 p.m. with the Administrator, two pendant sprinkler heads located in the ceiling of the 200 hall, 300 hall dining rooms and the oxygen transfill room on Service hall were measured to be forty eight inches apart. Based on interview on 03/30/15 concurrent with the observations with the Administrator, it was acknowledged the aforementioned sprinkler heads observed were less than six feet apart.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per</p>		to the area referenced. The facility will remove the sprinkler heads identified in the survey thus reducing the amount of coverage currently being provided by the sprinkler head configuration. Once removed no further follow up will be necessary.				

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	<p>month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p>	K 144	<p>No residents were affected by the alleged deficient practice. Maintenance Supervisor will document amperage during load test on the generator log maintained by the facility during the monthly testing. Administrator will monitor quarterly for compliance.</p>	04/30/2015	

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	<p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 03/30/15 at 3:44 p.m. with the Administrator, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating and no other method was used to document monthly load for the past twelve months. Based on interview on 03/30/15 concurrent with record review with the Administrator, it was acknowledged the facility had been running the generator monthly but did not document it to be at 30 percent and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>				