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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/17/2014 |
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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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| 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: 11/17/14</p> <p>Facility Number: 012565 Provider Number: 155791 AIM Number: 201021970</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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</p> | K010000 | <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 November 17, 2014. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully <u>requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</u></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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| K010052 SS=E | <p>a capacity of 55 and had a census of 54 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.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/20/14.</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 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 Based on observation and interview, the facility failed to ensure 1 of 12 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect 10 residents on 100 hall if there was a delay</p> | K010052 | <p>K 052 What corrective actions will be accomplished for residents found to have been affected by the deficient practice: The manual fire alarm box will be relocated inside the exit foyer in an area accessible when magnetic doors are locked down. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be</p> | 12/17/2014 |

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| K010062 SS=F | <p>in notifying staff of a fire emergency at the front entrance as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/17/14 at 12:45 p.m. with the Maintenance Supervisor the manual fire alarm box next to the front entrance was located in the exit foyer which was only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants. Based on interview on 11/17/14 at 12:47 p.m. with the Maintenance Supervisor it was acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview,</p> | K010062 | <p>taken: All residents residing in the Health Center are potentially affected by the alleged deficient practice. The manual fire alarm box will be relocated inside the exit foyer in an area accessible when magnetic doors are locked down. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: A weekly audit of fire alarm manual pull stations is conducted by plant operations personnell and this station location will be included in this audit. 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: Results of the audit will be reported to the facility QAA committee monthly by the Director of Plant Operations. The results will be reveiwed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 12/17/14</p> | 12/17/2014 | | K 062 | |

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| | <p>the facility failed to ensure 6 of 6 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Systems report on 11/17/14 at 3:31 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for six private fire hydrant outside around the facility. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of annual fire hydrant inspections was not available for review.</p> <p>3.1-19(b)</p> | | <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The fire hydrants are being serviced by the Peru Fire Department on an annual basis and after each operation. The campus will obtain a letter of certification from the Peru F.D. to document this service.</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 are potentially affected by the alleged deficient practice. The fire hydrants are being serviced by the Peru Fire Department on an annual basis and after each operation. The campus will obtain a letter of certification from the Peru F.D. to document this service.</p> <p>What measures will be put</p> | | | | |

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| | | | <p>into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>The annual inspection will be audited by the Director of Plant operations and written verification obtained of this service. This audit will be reported to the campus QAA committee when service occurs.</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>Results of the audit will be reported to the facility QAA committee monthly by the Director of Plant Operations. The 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>Completion Date: 12/17/14</p> | | |

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| K010143 SS=E | <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 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 8 residents on 200 hall as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 11/17/14 at 2:06 p.m. with the Maintenance Supervisor, the oxygen storage room on 200 hall west used to store and transfer oxygen was provided with an electrically powered vent but it was not working. Based on</p> | K010143 | <p>K 143</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice:</p> <p>The exhaust fan in question was immediately repaired on 11/17/14 and is now fully operational.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and</p> | 12/17/2014 | |

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| | interview on 11/17/14 at 2:10 p.m. it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and was unaware the vent was not working. 3.1-19(b) | | <p>what corrective actions will be taken:</p> <p>All residents are potentially affected by the alleged deficient practice. The exhaust fan in question was immediately repaired on 11/17/14 and is now fully operational.</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 exhaust fan in the oxygen room will be placed on a weekly audit to ensure it's proper function. Results of the audit will be reported to the facility QAA committee monthly.</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>Results of the audits will be reported to the facility QAA</p> | | |

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| K010144 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per 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</p> | K010144 | <p>committee monthly by the Director of Plant Operations. The 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>Completion Date: <u>12/17/14</u></p> <p>K 144 What corrective actions will be accomplished for residents found to have been affected by the deficient practice: The Director of Plant Operations or designee will begin doing monthly load bank calculations in addition to the annual load bank test done by the monitoring service. This will be documented on the appropriate worksheet to ensure compliance. 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 residing in the Health</p> | 12/17/2014 |

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| | <p>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> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 11/17/14 at 3:38 p.m. with the Maintenance Supervisor, 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 11/17/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly but could not document it to be at 30 percent and no other equivalent method was used to</p> | | <p>Center are potentially affected by the alleged deficient practice. The Director of Plant Operations or designee will begin doing monthly load bank calculations in addition to the annual load bank test done by the monitoring service. This will be documented on the appropriate worksheet to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The Director of Plant Operations will audit the worksheets monthly to ensure proper completion of the load bank calculations and report to the QAA committee. 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: Results of the audits will be reported to the facility QAA committee monthly by the Director of Plant Operations. The results will be received and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: 12/17/14</p> | | | | |

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| | comply with percentage of load capacity for the past twelve months. 3.1-19(b) | | | | |