

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/18/2015
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NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
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K 000  Bldg. 01	<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: 05/18/15</p> <p>Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860 3q</p> <p>At this Life Safety Code survey, Betz Nursing Home 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 114 and had a census of 102 at the time of this survey.</p>	K 000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

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 025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered generator room and a pole barn providing storage of maintenance equipment and general storage.</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 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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a</p>	K 025	<p>It is the practice of this provider to ensure that ceiling smoke barriers provide a one half hour fire resistance rating. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee has ensured that the ceiling smoke barriers provide at least one half hour of fire resistance and are continuous from outside wall to outside wall. The penetrations caused by pipe, cable or wire have been sealed using fire barrier caulking (penetrations in the barrier walls above the ceiling tiles of the 200</p>	06/10/2015
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	<p>material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 25 residents in 4 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Maintenance Supervisor on 05/18/15 from 1:20 p.m. to 2:35 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the 200 hall smoke wall measuring one fourth of an inch in size</p> <p>b) Above the ceiling tiles of the 100 hall smoke wall measuring one half of an inch in size</p> <p>c) In the attic of the service hall smoke wall measuring twelve inches in size.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be</p>		<p>hall smoke wall, above the ceiling tiles of the 100 hall smoke wall, and in the attic of the service hall smoke wall). The maintenance supervisor/designee has repaired the penetrations in room 202, the cottage lounge, the storage room by the old housekeeping office, the ADNS storage room, the mechanical room by dietary, the clean utility/call light room, and the 600 hall storage room. The penetrations around the attic hatch in the 400 mechanical room and the service hall have also been repaired using fire barrier caulk and now close completely and properly. All additional areas were inspected by maintenance supervisor/designee and vendor for compliance. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All penetrations have been repaired to meet this code. Access panels now close completely and properly. Maintenance supervisor/designee or contracted vendor inspected/ensured that all ceiling barriers provide the appropriate fire resistance and are continuous from outside wall to outside wall. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Preventive maintenance schedule</p>		

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	<p>continuous from an outside wall to an outside wall. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 05/18/15 between 10:00 a.m. and 2:00 p.m., the following unsealed penetrations in the ceiling were noted:</p> <ul style="list-style-type: none"> <li>a.) measuring a half of an inch to one fourth of an inch around sprinkler heads in room 202 and the Cottage lounge.</li> <li>b.) in the storage room by the old housekeeping office measuring one fourth of an inch in size.</li> <li>c.) four in the ADNS storage room measuring two inches to one eighth of an inch in size.</li> <li>d.) two in the housekeeping/sprinkler room measuring two inches to one eighth of an inch in size.</li> <li>e.) in the mechanical room by dietary</li> </ul>		<p>is implemented that will include checking access panels, and verifying penetrations of ceiling smoke barriers are properly sealed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will monitor per facility preventive maintenance manual monthly schedule. Any needed repairs will be completed immediately to ensure compliance. Findings will be reported for 3 months to the safety committee, and quarterly thereafter for 3 additional quarters.</p>				

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K 029 SS=E Bldg. 01	<p>measuring one fourth of an inch in size. f.) two in the clean utility/call light room measuring one inch to one eighth of an inch in size. g.) two in the 600 hall storage room measuring one half of an inch in size. h.) around the attic hatch in the 400 mechanical room measuring one half of an inch in size. i.) around the attic hatch in the service hall measuring one half of an inch in size caused by a cable going into the attic and preventing the hatch from completely closing. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</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</p>				

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	<p>permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 11 hazardous areas such as soiled utility rooms and combustible storage areas over 50 square feet in size were provided with self closers and would latch into the frame. This deficient practice could affect 25 residents within the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/18/15 between 10:46 a.m. to 12:38 p.m., the following doors to hazardous areas latched into the door frame but did not self close:</p> <p>a.) the Bath/Soiled Utility room in the 500 hall</p> <p>b.) the old housekeeping office which was greater than 50 square feet contained 23 large boxes filled with paper and fabric, and two large trash bags filled with fabric; the door lacked a self closing device.</p> <p>c.) the ADNS store room which was greater than 50 square feet contained 12 large boxes filled paper, was equipped with a self closing device but was held open with a device that did not release with the fire alarm.</p> <p>Based on interview at the time of</p>	K 029	<p>It is the practice of this provider to ensure that corridor doors to hazardous areas such as soiled utility rooms and combustible storage areas over 50 square feet in size are provided with self closers and will latch into the frame. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance supervisor/designee repaired the closer on the door to the Bath/Soiled Utility room in the 500 hall. The old housekeeping office has had boxes and trash bags of linens removed. This is no longer considered a combustible storage area so no closer is needed. The ADNS storage room has had the 12 boxes containing paper removed. The door stop was removed allowing the self closing device to release with the fire alarm How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The alleged deficient practice had the potential to affect 25 residents. The maintenance supervisor/designee has ensured that all self closers are properly functioning without any hindrance to the operation of the fire alarm system. Maintenance supervisor/designee checked all areas to ensure there were no other combustible storage areas</p>	06/04/2015			

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K 050 SS=F Bldg. 01	<p>observation, this was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <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 were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p>	K 050	<p>without appropriate door closers. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance supervisor/designee will monitor the affected areas monthly for 3 months and then as directed by the preventive maintenance schedule. IDT team was inserviced regarding combustible storage areas. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will report all findings at monthly safety committee meeting.</p> <p>It is the practice of this provider to conduct fire drills at unexpected times at least quarterly on each shift. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The third shift fire drill was</p>	05/30/2015	

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	<p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" with the Maintenance Supervisor on 05/18/15 at 09:30 a.m., there was no record of a third shift fire drill for the fourth quarter of 2014. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>conducted on 5-30-15 to ensure the staff was familiar with procedures. This was in addition to the drill that was required per schedule for May. The written fire drill schedule is now implemented to insure drills are conducted on each shift once per quarter. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will betaken? This alleged deficient practice had the potential to affect all residents. Maintenance director/designee will ensure the schedule is followed and all shifts have a fire drill conducted at least once per quarter. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The fire drill schedule (generic – without dates or times)for the entire year has been given to all IDT members to facilitate compliance. Maintenance supervisor/designee is responsible to schedule exact dates/times and communicate with the Executive director/designee for verification of each shift being completed once quarterly. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Fire drills are discussed at every monthly safety meeting. Proper shift timing will</p>		

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K 062 SS=E Bldg. 01	<p>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</p> <p>1. Based on observation and interview, the facility failed to replace 3 of over 300 sprinklers in the facility which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect up to 24 residents in the 700 hall, and activities room.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor on 05/18/15 between 10:40 a.m. and 1:00 p.m., the following automatic sprinklers had paint on the fusible link and/or the deflector:</p> <p>a. 1 of 6 sprinkler heads in the activities room</p>	K 062	<p>be verified to ensure each shift is completing a quarterly drill.</p> <p>It is the practice of this provider to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The 3 sprinkler heads that were found to have paint on the fusible link and/or the deflector have been replaced. The 3 sprinkler heads that had missing escutcheons have been replaced. All remaining sprinkler heads were checked by the vendor for compliance. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will betaken? 24 residents had the potential to be affected by the sprinkler heads with paint on them and 37 residents had the potential to be affected by the sprinkler heads with missing escutcheons. The contracted vendor completed the work on the 6 specified sprinkler heads.</p>	06/10/2015

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	<p>b. 1 of 3 sprinkler heads in the closet of room 705</p> <p>c. 1 of 1 sprinkler heads in the linen room in the 700 hall</p> <p>Based on interview at the time of observation, the painted sprinkler heads were acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of over 300 sprinklers in the facility were properly maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect up to 37 residents in the 200 and 100 halls.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/18/15 between 10:16 a.m. to 12:30 p.m., the sprinkler heads in the closets of rooms 203, 207, and 104 were missing the escutcheons. Based on interview at the time of observation, this was acknowledged by the Maintenance</p>		<p>Vendor and maintenance supervisor/designee examined all remaining sprinkler heads for compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance supervisor/designee will observe sprinkler heads according to the preventive maintenance schedule. Contracted vendor will also inspect entire building annually to ensure sprinkler heads are in reliable operating condition. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool will be completed quarterly. The tool will be reviewed at the applicable safety meeting as well as the CQI meeting.</p>		

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	Supervisor.  3.1-19(b)				