STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2013
NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947	

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K020000	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: 12/16/13 Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810 Surveyor: Phillip Komsiski, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist At this Life Safety Code survey, Camelot Care 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. 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	K020000	Submission of this Plan of Correction does not consititute an admission of agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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	corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 59 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had one detached wood shed which is used to store activities supplies which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/23/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K020025 SS=E	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			

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	Based on observation and interview, the facility failed to ensure 2 of 5 smoke barrier walls were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire 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 2 residents on Main hall and 22 residents on Boys hall as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall. Findings include: Based on observations on 12/16/13 during the tour between 12:50 p.m. and 1:30 p.m. with the Maintenance Supervisor, the Main hall smoke barrier wall had a four inch diameter hole located at the center right of wall with five wires penetrating the smoke barrier which was not sealed with a fire rated material. Also, the Boys hall smoke barrier wall had a three inch diameter hole with five wires penetrating the smoke barrier and it was not sealed with	K020025	1. No residents were affected. 2. The space between the penetration items in the 2 of 5 smoke barrier walls has been filled with a material capapble of maintaining the smoke resistance of the smoke barrier. 3. All smoke barrier walls were inspected to ensure they were protected to maintain the one half hour fire resistance rating ot the smoke barrier. Preventative Maintenance check list has been updated to include inspection of smoke barrier walls. 4. Maintenance supervisor will report the results to the quality assurance committee monthly for 3 months and quarterly thereafter.	01/03/2014

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	a fire rated material. Based on interview on 12/16/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier walls had unprotected openings which were not sealed with a fire rated material. 3.1-19(b)			
K020038 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 access was arranged so 2 of 8 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1.10.1 requires means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC Section 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. This deficient practice could affect 4	K020038	1. No residents were affected. 2. The 2 affected exits were made readily accessible immediately. 3.The maintenance supervisor was re-eduated on the importance of maintianing exits to be readily accessible at all times. 4. Ensuring exits are readily accessible at all times was added to maintenance supervisors daily rounds as well as administrators daily rounds. Maintenance supervisor will report the results of his daily rounding of exits being readily accessible to the quality assurance committee monthly for	01/03/2014

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	residents on Main Administrative hall and 22 residents on Boys halls as well as visitors and staff. Findings include: Based on observations on 12/16/13 during the tour between 1:22 p.m. and 1:25 p.m. with the Maintenance Supervisor, the cement walkway used to discharge residents on Main Administrative hall had two inches of snow on the walkway leading to the public way. Furthermore, the Boys hall exit had four inches of snow on the walkway leading to the public way. Based on interview on 12/16/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the facility had neglected to keep the aforementioned exit walkways free and clear of snow. 3.1-19(b)		3 months and quarterly thereafter.	

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K020052 SS=F	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 maintain 1 of 1 fire alarm systems in accordance with NFPA 72, 1999 Edition, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. This deficient practice could affect all residents as well as staff and visitors. Findings include: Based on observation on 12/16/13 at 3:00 p.m. with the Maintenance Supervisor, the primary phone line from the dialer was disconnected and after more than 200 seconds transpired, no signal was heard and no trouble light	K020052	1. No residents were affected. 2. Frontier provided service and connected system to ensure a trouble signal on the dialer to be activated and transmitted to the front desk when the dialer is disconnected. 3. Montly fire alram test report has been updated to include inspection of trouble signal to be activated, to be distictive and descriptively annunciated. 4. Maintenance supervisor will report the results to the quality assurance committee monthly for 3 months and quarterly thereafter.	01/03/2014

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	was observed on the fire alarm panel next to the front entrance next to the reception desk or anywhere else in the facility. Based on interview on 12/16/13 at 3:15 p.m. with the Maintenance Supervisor, it was acknowledged when the fire alarm system was placed into trouble when the primary phone line from the dialer was disconnected, a visual trouble signal on the dialer was not activated and was not transmitted to the (FACP) next to the reception desk by the front entrance. 3.1-19(b)			
K020068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 gas dryers in the laundry room on Main Administrative hall were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical	K020068	1. No residents were affected. 2. Upon observation with the life safety code inspector and the new manintenace supervisor there was a vent in the room but the maintnance man was unsure if this was an intake combustion air from the outside. Through further investigation with new maintenance supervisor and previous maintenance supervisor	01/03/2014

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	problems for 4 residents on Main Administrative hall as well as visitors and staff. Findings include: Based on observation on 12/16/13 at 12:57 p.m. with the Maintenance Supervisor, the two gas fueled dryers in the laundry room did not have a fresh air intake. Based on interview on 12/16/13 at 12:59 p.m. it was acknowledged by the Maintenance Supervisor, the gas fuel fired dryers did not have a fresh air intake. 3.1-19(b)		it was determined that this vent is an intake combustion air vent from the outside therefore no further action is required.	
K020144 SS=F	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. 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	K020144	1. No residents were affected. 2. The formula to verify 30 percent of the EPS nameplate rating has been added to the monthly generator log test. 3. Maintenance supervisor will document the percent of the EPS nameplate rating to ensure it is not less than 30 percent. 4.	01/03/2014

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	(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: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 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. Findings include: Based on review of Generator System Testing records and Maintenance logs on 12/16/13 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load was documented, but the Maintenance Supervisor could not verify it to be 30 percent of the EPS nameplate		Maintenance supervisor will report the results to the quality assurenace committee monthly for 3 months and quarterly thereafter. At this time the EPS namplate rating is not at 30 percent. The corporate maintenance supervisor will be be here the week of 1-13-14 to update the generator to reach compliance of 30 percent of the EPS nameplate rating.	

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	rating for the past twelve months. Based on interview on 12/16/13 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but were unaware it had to be at least 30 percent of the EPS rating. No other equivalent method was used to comply with percentage of load capacity for the past twelve months. 3.1-19(b)			
K020147 SS=E	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 1 of 6 electrical junction boxes observed containing electrical wiring were contained in the junction boxes with covers. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 4 residents on Main Administrative hall as well as visitors and staff.	K020147	1. No residents were affected. 2. A compatible cover was installed over the junction box. 3. All other electrical junction boxes were inspected to ensure proper coverings were in place. Preventative Maintenance check list has been updated to include inspection of electrical junction boxes. 4. Maintenance Supervisor will report fincings to the quality assurance committee monthly for three months and quarterly thereafter.	01/03/2014

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	Findings include: Based on observation on 12/16/13 at 1:15 p.m. with the Maintenance Supervisor, a total of eight electrical wires were jutting out of a one foot square electrical junction box without a cover above the Main Administrative hall smoke barrier wall. Based on interview on 12/16/13 at 1:17 p.m., it was acknowledged by the Maintenance Supervisor the electrical wires jutting out of the electrical junction box were not protected with a cover. 3.1-19(b)			