

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2011
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NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN46947
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K0000	<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: 10/04/11</p> <p>Facility Number: 000021 Provider Number: 155710 AIM Number: 100275270</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Chase 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 with a partial basement 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 battery operated detectors in all resident</p>	K0000	<p><u>Disclaimer</u></p> <p>Chase Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. Chase Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position, and Chase Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Chase Center does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Chase Center offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.</p> <p>Chase Center reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.</p>	

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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K0018 SS=E	<p>sleeping rooms. The facility has a capacity of 101 and had a census of 83 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/11/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 2 sets of corridor doors by the front entrance would latch into their frame. This deficient practice could affect 12 residents observed in the Main dining room as well as visitors and staff.</p>	K0018	<p>K 018 <u>Corrective action(s) for those identified:</u> The facility will make improvements to the north set of corridor doors leading into the main dining room, so that the doors are provided with a means suitable for keeping them closed.</p> <p>- <u>Identification of others potentially</u></p>	12/02/2011	

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	<p>Findings include:</p> <p>Based on observation on 10/04/11 at 12:35 p.m. with the Maintenance Supervisor, the north set of corridor doors leading into the Main dining room did not latch into their frame. Based on interview on 10/04/11 at 12:37 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned doors would not latch into their frame.</p> <p>3.1-19(b)</p>		<p><u>affected:</u></p> <p>Maintenance staff has inspected all corridor doors throughout the facility, in order to determine whether these doors are provided with a means suitable for keeping them closed. For any corridor door identified without means suitable for keeping it closed, the facility will make improvements to the door, so that the door is provided with a means suitable for keeping it closed.</p> <p><u>Measures to prevent recurrence:</u></p> <p>Monthly, maintenance staff will inspect all corridor doors throughout the facility, in order to determine whether all corridor doors are provided with a means suitable for keeping them closed. For any corridor door identified without a functioning means suitable for keeping it closed, maintenance staff will repair the corridor door, so that it has a means suitable for keeping the door closed.</p> <p>Monthly, the maintenance director will provide the administrator with a written report that details the results of inspections of the corridor doors throughout the facility and describes the actions taken, if any, to ensure that all corridor doors are provided with means suitable for keeping them closed.</p> <p><u>Monitoring:</u></p> <p>Monthly, the administrator will</p>		

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K0027 SS=E	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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 10 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors will always close completely as a pair. The Centers for	K0027	report to the Quality Assurance (QA) sub-committee regarding the results of the maintenance inspections, including the identification of any corridor doors that required improvements, as well as what actions were taken to ensure that the corridor doors are provided with means suitable for keeping them closed. At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of this "deficient practice" and the steps for monitoring are carried out as described.	11/03/2011

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	<p>Medicare &amp; Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and are equipped with an astragal to have a coordinator to ensure the door without the astragal always closes first. This deficient practice could affect 32 residents on Burlington hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 10/04/11 during the tour between 2:01 p.m. and 2:59 p.m. with the Maintenance Supervisor, the set of smoke doors on Burlington hall next to the nurses' station which swung in the same direction and were equipped with an astragal lacked a coordinator and the smoke doors on Burlington hall at the entrance to Burlington hall which swung in the same direction and were equipped with an astragal lacked a coordinator.</p> <p>Based on interview on 10/04/11 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned sets of smoke doors which swung in the same direction lacked a coordinator to allow the door without the astragal to close first.</p> <p>3.1-19(b)</p>		<p>between the main dining room and the Burlington Hall.</p> <p><u>Corrective action(s) for those identified:</u> On 10/13/11, for the set of smoke doors in the hallway between the main dining room and the Burlington Hall, maintenance staff installed a coordinator to ensure that the door without the astragal will close first.</p> <p><u>Identification of others potentially affected:</u> Maintenance staff inspected all smoke barrier doors which swing in the same direction and are equipped with an astragal. Maintenance staff determined that no other set of smoke barrier doors is lacking a coordinator to ensure the door without the astragal always closes first.</p> <p><u>Measures to prevent recurrence:</u> Monthly, maintenance staff will inspect each set of smoke barrier doors which swing in the same direction and are equipped with an astragal, in order to ensure that the door without the astragal always closes first. In case any set of such doors does not close in the required manner, maintenance staff will repair the door(s) or the coordinator. Monthly, the maintenance director will provide the administrator with a written report that details the results of</p>		

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			<p>inspections of the smoke barrier doors which swing in the same direction and are equipped with an astragal, describing the actions taken, if any, to ensure that every set of such smoke barrier doors is equipped with a coordinator that enables the door without the astragal to always close first.</p> <p><u>Monitoring:</u> Monthly, the administrator will report to the Quality Assurance (QA) sub-committee regarding the results of the maintenance inspections, including the identification of any set of smoke barrier doors that required repairs, as well as what actions, if any, were taken to ensure that every set of such smoke barrier doors is equipped with a coordinator that enables the door without the astragal to always close first.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of this "deficient practice" and the steps for monitoring are carried out as described.</p>		

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K0051 SS=E	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 smoke detectors on Burlington hall and 2 of 7 smoke detectors on Monticello hall were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 25 residents on Burlington hall and 23 residents on Monticello hall as well as visitors and staff.</p> <p>Findings include:</p>	K0051	<p>K 051 <u>Corrective action(s) for those identified:</u> On 10/14/11, maintenance staff relocated the identified smoke detectors, so that they are not located within three feet of an air return vent.</p> <p>- <u>Identification of others potentially affected:</u> Maintenance staff inspected the location of all other smoke detectors. No other smoke detectors were identified to be within three feet of an air diffuser.</p> <p><u>Measures to prevent recurrence:</u> At the time any new smoke detectors are installed, the maintenance director will ensure that the smoke detectors are not</p>	11/03/2011	

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	<p>Based on observations on 10/04/11 during the tour between 12:45 p.m. and 1:38 p.m. with the Maintenance Supervisor, the following smoke detectors were within three feet of an air diffuser:</p> <p>a. Two smoke detectors next to the nurses' station on Burlington hall were within two feet of an air return vent,</p> <p>b. Two smoke detectors next to the nurses' station on Monticello hall were within two feet of an air return vent.</p> <p>Based on interview on 10/04/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor the aforementioned smoke detectors were installed within three feet of an air return vent in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>		<p>installed in locations where air flow would prevent function of the detectors to their fullest capability; namely, not installed within three feet of an air diffuser.</p> <p><u>Monitoring:</u> At the installation of any new smoke detectors, the maintenance director will report to the QA sub-committee, which meets twice monthly, regarding the location of such detectors, in order to verify that the detectors are not located within three feet of an air diffuser.</p> <p>At each quarterly meeting, the full Quality Assurance (QA) Committee, including the Medical Director, Administrator, and Director of Nursing, will review the reports and actions of the QA sub-committee, in order to assure that the measures to prevent recurrence of this "deficient practice" and the steps for monitoring are carried out as described.</p>		