

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962
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K020000	<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: 01/26/15 and 01/27/15</p> <p>Facility Number: 000485 Provider Number: 155655 AIM Number: 100291190</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist; Brett Overmyer, Life Safety Code Supervisor</p> <p>At this Life Safety Code survey, Peabody Retirement Community 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 facility consists of Health Care Center South a fully sprinklered two story building of Type II (111) construction, Health Care North and Smock Memory Enhancement Center both are one story fully sprinklered</p>	K020000		
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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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K020029 SS=E	<p>buildings of Type II (111) construction, and Therapy Center is a one story fully sprinklered buildings of Type II (000) construction. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 192 and had a census of 173 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 02/02/15.</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 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>1. Based on observation and interview,</p>	K020029	1. There were no residents adversely affected by this	02/26/2015			

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	<p>the facility failed to ensure the corridor door to 1 of 1 nursing admin restrooms used to store combustibles and measuring over 50 square feet in size was provided with a self closing device. This deficient practice was not in resident treatment area but could affect staff in the area.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facility Services and the Maintenance Director on 01/26/15 at 2:23 p.m., the corridor door to the nursing admin restroom which contained over 25 boxes of paper files and shoes and measured over 50 square feet in size, lacked a self closing device. This was acknowledged by the Director of Facility Services and the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ceiling penetrations in a hazardous area was maintained to provide a one hour fire resistance rating. This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p>		<p>non-compliance. 2. As all residents have the potential to be affected, the restroom has been empty as of February 12, 2015 and will no longer used as a storage room. 3. The Director of Facility Services / designee will audit all storage rooms weekly for the next month and then monthly moving forward to ensure that all doors have self-closing devices and all items are at least 18 inches from ceiling. Maintenance staff will be in-serviced on February 13, 2015 on deficient practice. 4. The Director of Facility Services / Designee will present to QAPI monthly to ensure that rounds are completed and to report any findings that may occur.5. This will be completed by February 26, 2015 1. There were no residents adversely affected by this non-compliance. 2. As all residents have the potential to be affected the unsealed penetrations have been filled with Fire Foam and Fire Caulk as of February 12, 2015. 3. The Director of Facility Services /Designee will do monthly audits to insure that all penetrations stay sealed. All maintenance staff will be in-serviced on February 13, 2015. 4. The Director of Facility Services / Designee will present to QAPI monthly to ensure that rounds are completed and to report any findings that may occur.5. This will be completed by February 26,</p>				

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	<p>Based on observation and interview with the Director of Facility Services and the Maintenance Director on 1/26/15 between 1:00 p.m. and 3:00 p.m. and on 1/27/15 at 10:53 a.m. the following was acknowledged:</p> <p>(a) In the soil holding room located in health care north by room 105 had unsealed penetrations about 1/2 inch to inch in size around wires and piping.</p> <p>(b) In the soil holding room located in health care north by the nurses ' station had an unsealed penetration about 3/4 inch in size around wires and piping.</p> <p>(c) In the electrical room by health care south had a one inch by two inches rectangular penetration in the wall near the door.</p> <p>Based on interview, measurements were provided by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 6 of 6 corridor double doors to a hazardous area provided with self closing devices with automatically latching devices. This deficient practice could affect all residents in healthcare north, healthcare south one and healthcare south two.</p> <p>Findings include:</p>		<p>2015 1. There were no residents adversely affected by this non-compliance. 2. As all residents have the potential to be affected the closing automatic positive latching devices will be installed by Florey Construction on February 26, 2015. 3. The Director of Facility Services / Designee will audit the working status of the new self closing devices weekly for the next month to ensure everything is working well then monthly there after. Maintenance staff will be in-serviced on February 13, 2015. 4. The Director of Facility Services / Designee will present this to QAPI the next 2 months to ensure that rounds are completed and to report any findings that may occur. 5. This will be completed by February 26, 2015</p>				

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K020050	<p>Based on an observation with the Director of Facility Services and the Maintenance Director on 1/26/15 between 12:00 p.m. and 3:00 p.m., and on 1/27/15 at 11:20 a.m., the following was noted:</p> <p>(a) in healthcare north's dining room which is open to the kitchen, the two sets of double doors to the corridor were equipped with manual slide bolts and lacked automatic positive latching hardware on the doors.</p> <p>(b) In healthcare south one's dining room which is open to the kitchen, the two sets of double doors to the corridor were equipped with manual slide bolts lacked automatic positive latching hardware on the doors.</p> <p>(c) in healthcare south two's dining room which is open to the kitchen, the two sets of double doors to the corridor were equipped with manual slide bolts lacked automatic positive latching hardware on the doors.</p> <p>Based on interview, this was acknowledged by the Director of Facility Services and the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			
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SS=C	<p>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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the " Fire Alarm Report" forms with the Director of Facility Services and the Maintenance Director on 01/26/15 at 10:26 a.m., all third shift fire drills took place between 1:50 a.m. and 2:30 a.m. for four of the last four quarters. Based on interview, this was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K020050	<p>1. There were no residents adversely affected by this non-compliance. 2. As all residents have the potential to be affected, the fire drill schedule now incorporates varying times that the drills shall be performed. This was completed on February 11, 2015. 3. The Director of Facility Services / designee will in-service the staff on the new fire drill schedules. 4. The Director of Facility Services / Designee will present to QAPI monthly to ensure that the times meet the Life Safety code. 5. This will be completed by February 26, 2015</p>	02/26/2015			
K020061 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have</p>						

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K020062 SS=E	<p>valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system post indicator valves (PIV) was electronically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facility Services and the Maintenance Supervisor on 01/26/15 at 2:30 p.m., the PIV was locked in the open position with a pad lock, however, an electronic tamper device was not observed on the PIV.</p> <p>Based on interview at the time of observation, the Director of Facility Services and the Maintenance Supervisor acknowledged the PIV was not electronically supervised.</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</p>	K020061	<p>1. There were no residents adversely affected by this non-compliance. 2. All residents have the potential to be affected so the electronic tamper device will be installed by Priority 1 by February 26, 2015. 3. The Director of Facility Services/ Designee will in-service Maintenance staff on the new electronic tamper device on February 13, 2015. 4. The Director of Facility Services / Designee will report to QAPI in the month of March that all steps in the action plan have been completed. 5. This will be completed by February 26, 2015</p>	02/26/2015			
	<p>1. Based on observation and interview, the facility failed to replace the sprinkler head in 1 of 4 beauty shops and 1 of 4 laundry rooms. LSC 9.7.5 requires all</p>	K020062	<p>1. There were no residents adversely affected by this non-compliance. 2. All residents have the potential to be affected so Current Fire</p>	02/26/2015			

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	<p>automatic sprinkler systems shall be inspected 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 affects 45 residents in health care north and 46 residents in Memory Enhancement Center.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facility Services and the Maintenance Supervisor on 01/26/15 between 12:15 p.m. and 1:31 p.m., the following was noted:</p> <p>a. A sprinkler head in the Willow Way's laundry room was corroded with a green substance.</p> <p>b. A sprinkler head in the Memory Enhancement Center's soil holding room side C was corroded with a green substance.</p> <p>Based on interview, this was acknowledged by the Director of Facility Services and the Maintenance Supervisor at the time of observation.</p>		<p>Protection Inc. will have the new sprinkler heads installed by February 26, 2015. 3. The Director of Facility Services / Designee will do audits monthly to check sprinkler heads. Maintenance staff will be in-serviced on identifying corrosion of sprinkler heads on February 13, 2015. 4. The Director of Facility Services / Designee will present to QAPI monthly to ensure rounds are completed and report any findings. 5. This will be completed by February 26, 2015</p> <p>1. There were no residents adversely affected by this non-compliance. 2. All residents have the potential to be affected so Current Fire Protection Inc. will have the fire sprinkler head moved by February 26, 2015. 3. The Director of Facility Services / Designee will meet with Current Fire once work is complete to ensure everything meets Life Safety codes. 4. The Director of Facility Services / Designee will report to QAPI in the month of March to report that all steps in the action plan have been completed. 5. This will be completed by February 26, 2015</p>				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads within the soil holding room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice does not directly affect residents since this area is accessible to only staff members.</p> <p>Findings include:</p> <p>Based on observation on 01/26/14 at 12:51 p.m. with the Director of Facility Services and the Maintenance Supervisor, the one sprinkler head in the soil holding room located in Willow Way across from room 141 was obstructed by air handler ductwork in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the</p>						

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K020067 SS=F	<p>room. Based on interview at the time of observation the Maintenance Supervisor acknowledged that the spray pattern of the sprinkler head would not provide adequate coverage of the room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview, the facility failed to ensure all fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be</p>	K020067	<p>1. There were no residents adversely affected by this non-compliance. 2. All residents have the potential to be affected so the Maintenance staff will inspect 50 dampers a month until all dampers have been inspected. Once all dampers are serviced we will do one building per year to get them in a rotation so they are all completed every 4 years. Maintenance staff was in-serviced by Dave Altimus Maintenance Supervisor. He is a licensed HVAV and plumber. Dave in-serviced them on how to inspect and service dampers on February 13, 2015. 2015 3. The Director of Facility Services / Designee will audit monthly for</p>	02/26/2015

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	<p>checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/26/15 at 10:41 a.m. with the Director of Facility Services and the Maintenance Supervisor; they indicated there were no inspection records available for review for any of the facility's fire dampers. During interview on 1/26/15 at 10:41 the Director of Facility Services and the Maintenance Supervisor stated that they were not sure if the facility had fire dampers, and they would have to verify if the facility was equip with them. On 1/27/15 at 9:15 a.m. the Director of Facility Services and the Maintenance Supervisor verified that the facility was equip with fire dampers and no service had ever been completed on the dampers.</p> <p>3.1-19(b)</p>		<p>the next 6 months to ensure that they are completed. 4. The Director of Facility Services / Designee will present to QAPI monthly for the next 6 months or until all dampers have been inspected.5. This will be completed by July 26, 2015</p>		