

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
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NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN 47501
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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: 09/05/13</p> <p>Facility Number: 000301 Provider Number: 155341 AIM Number: 100289090</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Eastgate Manor Nursing & Rehabilitation 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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery</p>	K010000	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</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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	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 82 and had a census of 64 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, except a detached wood framed garage used for maintenance and facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen service metal rolling doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 09/05/13 at 12:25 p.m. during a tour of the facility with the Maintenance Director, the metal rolling service door between the kitchen and dining room was held open with chains and fusible link which would not allow the door to close automatically when the fire alarm system was activated.</p>	K010021	Metal rolling service door between the kitchen and dining room has been connected to the fire system which will allow the door to close automatically when the fire alarm system is activated. Rolling fire door will be inspected and tested annually to check for proper operation and full closure.	10/04/2013			

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	<p>Based on interview at the time of observation, the Maintenance Director acknowledged the metal roller door between the kitchen and dining room was held open with a chain and fusible link which would not allow the door to close automatically when the fire alarm system was activated.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 10 exit doors was readily accessible. This deficient practice could affect up to 10 residents, as well as staff and visitors in the Activity Room and up to 18 residents, as well as staff and visitors in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observations on 09/05/13 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, the exit door from the Activity room and the exit door from the southwest Skilled Unit were both very difficult to open. Both doors had to be kicked open at the bottom opening side edge of each door because they were both rusted and stuck to the door frame and threshold. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>	K010038	<p>Replacement exit doors from the Activity room and the exit door from the southwest skilled unit have been ordered. Estimated date of delivery and install is Oct. 25th. Exit doors in building were checked for malfunctions. Administrator and Maintenance Director will perform weekly rounds to ensure that the deficient practice does not reoccur. Any reoccurrences identified will be rectified immediately.</p>	10/04/2013

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 64 of 64 residents to accurately address all life safety systems such as the use of the K-class fire extinguisher in the kitchen and staff response to battery operated smoke detectors in resident rooms thus addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 09/05/13 at 10:15 a.m. with the Maintenance Director</p>	K010048	Fire safety manual updated to accurately address use of the K-Class fire extinguisher and staff response to battery operated smoke detectors in resident rooms. Staff will be inserviced on use of the K-Class fire extinguisher and response to battery operated smoke detectors in resident rooms.	10/04/2013			

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	<p>present, the Fire Procedures in the Disaster Preparedness Manual did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, or staff reaction to a resident room battery operated smoke detector if activated. Based on interview at the time of record review, the Maintenance Director acknowledged the Fire Procedures did not accurately address the use of the K-class fire extinguisher in the kitchen and staff reaction to battery operated smoke detectors in resident sleeping rooms.</p> <p>3.1-19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 5 smoke compartments. This deficient practice could affect up to 10 residents, as well as staff and visitors while in the Activity room.</p> <p>Findings include:</p> <p>Based on observation on 09/05/13 at 1:00 p.m. during a tour of the facility with the Maintenance Director, the sprinkler riser room located within the Activity room had an eighteen inch bulkhead in the middle of the room. There was a pendent type sprinkler head within the room, however, the bulkhead would prevent sprinkler coverage to all portions of the room. Based on interview, this was</p>	K010056	Additional sprinkler head to be added in sprinkler room to provide sprinkler coverage to all portions of the room. Facility will continue to have sprinklers inspected and tested periodically.	10/04/2013			

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	acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)			

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K010062 SS=C	<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 ensure only one type of sprinkler head, i.e., quick response or standard sprinklers was installed in a compartmented space in 1 of 5 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents, as well as staff and visitors while in the dining room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 09/05/13 at 12:40 p.m. during a tour of the facility with the Maintenance Director, three of ten sprinkler heads in the dining room were quick response sprinkler heads and the other seven were standard response sprinkler heads. This was acknowledged by the Maintenance Director at the time of observation.</p>	K010062	The three quick response sprinkler heads in the dining room are to be removed and replaced with standard response sprinkler heads. Facility will continue to have sprinklers inspected and tested periodically.	10/04/2013			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 09/05/13 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, the spare sprinkler head cabinet in the facility had more than six spare sprinkler heads, however, there were no sidewall, quick response sprinkler heads or pendent quick response sprinkler heads included. Sidewall quick response sprinkler heads were observed in the walk in cooler (now kitchen dry storage room), and pendent quick response sprinkler heads were observed in the dining room. This was acknowledged by the Maintenance Director at the time of observations, furthermore, the Maintenance Director indicated there</p>						

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	<p>were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>			

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could all residents, as well as staff and visitors while using the dining room which is large enough to seat all residents, and is located adjacent to the kitchen rolling fire door.</p> <p>Findings include:</p> <p>Based on observation on 09/05/13 at 12:25 p.m. during a tour of the facility</p>	K010130	Rolling fire door was inspected and tested to check for proper operation and full closure. Rolling fire door to be inspected and tested annually to check for proper operation and full closure and a written record shall be maintained.	10/04/2013	

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	<p>with the Maintenance Director, the metal rolling fire door protecting the opening from the kitchen to the dining room was without an inspection tag. Based on interview at the time of observation, this was confirmed by the Maintenance Director, furthermore, the Maintenance Director stated there was no additional documentation of an annual inspection or test for the kitchen rolling fire door to check for proper operation and full closure of the metal curtain.</p> <p>3.1-19(b)</p>			