

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155775	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2013
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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906
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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: 08/07/13</p> <p>Facility Number: 000547 Provider Number: 155775 AIM Number: 100267440</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cumberland Pointe Health Campus was found not in compliance with Requirements for Participation in 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>The certified health care beds in this facility were located on the east and west wings of a one story building determined to be of Type V (111) construction which was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open</p>	K010000	<p>Survey Event ID: KKSH21The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. The facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19) programs. To this end this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</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>to the corridors and in 23 west wing resident rooms. 19 east wing resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 71 and had a census of 61 at the time of this survey.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010029 SS=E	<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 permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure openings through ceiling and wall smoke barriers in 2 of 4 hazardous area smoke barriers were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. 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 visitors, staff and 10 or more residents with access to the smoke compartment adjacent to the service corridor.</p> <p>Findings include:</p>	K010029	<p>CORRECTIVE ACTION: The foam was observed in the laundry room and the bio-hazard room. The foam has been removed and replaced with a fire rated caulk that meets the standard.</p> <p>IDENTIFY OTHER RESIDENTS: All residents with the potential to be affected were identified in the finding. No other residents would have the potential to be impacted.</p> <p>MEASURES/SYSTEMIC CHANGES: The Plant Operations staff will be in-serviced regarding the requirement for all penetrations in smoke barriers to be filled with a properly approved fire rated caulk. Smoke barriers in the entire campus have been audited to ensure all penetrations are filled with a fire rated caulk. An audit form is being created to document monthly inspection of smoke barriers. MONITORING</p> <p>CORRECTIVE ACTION: The</p>	08/30/2013			

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	<p>Based on observation with the administrator on 08/07/13 between 11:30 a.m. and 3:30 p.m., two, one inch gaps in the wall of the boiler room and a half inch gap in the biohazard storage room ceiling had been filled with an expandable foam. The administrator acknowledged at the time of observations, the expandable foam was used in lieu of a material designed for the hazardous areas.</p> <p>3.1-19(b)</p>		<p>monthly audit results will be reported to the QA committee for three months. If any negative trends are noted in the audit results, the monthly review will be extended an additional three months to ensure full compliance.</p>		

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K010054 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 109 of 109 smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. NFPA 72, at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity</p>	K010054	<p>CORRECTIVE ACTION: The smoke detector sensitivity tests had been completed on 10/25/11 by the previous contractor and remained within compliance as they were tested within the past 2 years. The test results were available in the Plant Operations Director files and indicate all smoke detectors passed the sensitivity testing. IDENTIFY OTHER RESIDENTS: All residents with the potential to be affected were included in the finding. No other residents would have the potential to be impacted. MEASURES/SYSTEM CHANGES: The results of the smoke detector sensitivity tests are now available in the Plant Operations Inspections binder to ensure they are available for review at any time. MONITORING CORRECTIVE ACTION: The Executive Director will review the Plant Operations Inspections binder quarterly for 6 months to ensure documentation remains available for the current smoke detector sensitivity testing every 2 years. Results of the quarterly audit will be reported to the QA Committee quarterly for 6 months.</p>	08/07/2013
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	<p>test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. Note: The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the facility fire system inspection reports on 08/07/13 at 3:00 p.m. with the administrator, a record of sensitivity testing was not found. The administrator called the fire systems contractor immediately, but no record of a test was forthcoming. The administrator acknowledged at the time of record review, the sensitivity testing was not found.</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 insure a sprinkler providing protection for a room in 1 of 9 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 4-6.4.1 which requires the distance between the deflector and ceiling shall be a minimum of 1 inch. This deficient practice could affect visitors, staff and 10 or more residents in the Chapel.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/13 at 12:05 p.m., one pendant sprinkler head in the chapel was located above the cutout provided for installation of the sprinkler. The administrator agreed at the time of</p>	K010056	<p>CORRECTIVE ACTIONS: Per the guidance and report of the contracted sprinkler installer, the sprinkler head observed by the surveyor in the chapel is an approved concealed sprinkler head that was used in this small section of the chapel. The cover for the concealed sprinkler head was missing. However, the sprinkler installer indicates that the sprinkler has been and remains fully functional. A cover for the concealed sprinkler head has been ordered and will be placed. IDENTIFY OTHER RESIDENTS: All residents with the potential to be affected were identified in the finding. No other residents would have the potential to be impacted. MEASURES/SYSTEM CHANGES: An inspection of all ceiling sprinkler heads in the campus will be performed to</p>	09/06/2013			

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	<p>observation, the sprinkler head was located above the ceiling and the ceiling would obstruct any spray pattern if the sprinkler was activated.</p> <p>3.1-19(b)</p>		<p>ensure that any other concealed sprinkler heads are identified and noted in the Plant Operations Inspections binder. An in-service will be provided to all Plant Operations staff regarding the location of concealed sprinkler heads in the campus.</p> <p>MONITORING CORRECTIVE ACTION: Any additions or changes to the existing sprinkler system will be reviewed by the Director of Plant Operations to ensure that any concealed sprinkler heads are identified and that staff are aware of the changes and locations.</p>		