

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
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K 0000 Bldg. 01	<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: 07/09/15</p> <p>Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450</p> <p>At this Life Safety Code survey, Waldron Health and Rehab 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 79 and had a census of</p>	K 0000	<p>Credible Allegation of Compliance</p> <p>This plan of correction is the facility's Credible Allegation of Compliance.</p> <p>Preparation and/or execution of this plan of correction doesnot constitute admission or agreement by the provider of the truth of the factsalleged or conclusions set forth in the statement of deficiencies. The plan ofcorrection is prepared and/or executed solely because it is required by theprovisions of the Federal and State law.</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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K 0025 SS=F Bldg. 01	<p>56 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden garage and wooden shed which were not sprinkled.</p> <p>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</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 4 of 4 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable 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</p>	K 0025	<p>K 25 This finding was not found to have a direct affect on any specific resident. The finding had the potential to have affected all residents of the facility due to the attic smoke barriers location throughout the facility.</p> <p>The Maintenance Manager who was present for tour with the ISDH LSC Surveyor, will close and seal penetrations in the attic smoke barrier using fire rated materials (5/8 inch fire rated dry wall, 3M fire rated red caulking).</p> <p>The Maintenance manager will utilize TELS maintenance checklist for LSC compliance</p>	08/08/2015

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	<p>deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 07/09/15 from 12:25 p.m. to 12:55 p.m., the following attic smoke barrier walls had penetrations not firestopped;</p> <ol style="list-style-type: none"> 1. The West Hall attic smoke barrier wall had five, one to three inch circular gaps around electrical wiring conduit and water piping penetrations with no fire stopping material used to seal the gaps. 2. The North Hall attic smoke barrier wall had six, one inch to three inch circular gaps around electrical wiring conduit and water piping penetrations with no fire stopping material used to seal the gaps. 3. The South Hall attic smoke barrier wall had five, one inch to three inch circular gaps around electrical wiring conduit and water piping penetrations with no fire stopping material used to seal the gaps and a two foot by two foot area of double drywall missing near the center of the smoke barrier wall. 4. The Rehabilitation Hall attic smoke barrier wall had three, one inch to three inch circular gaps around electrical wiring conduit penetrations and three open electrical conduit pipes with no fire 		<p>which lists the inspection of fire barrier walls in attic on monthly rounding. Maintenance manager will document in TELS the task inspection completion. The Executive Director will review monthly x 3 months the TELS checklist to audit smoke barrier inspection. Audit findings will be reviewed in facility QA&A committee meeting.</p>	

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K 0062 SS=F Bldg. 01	<p>stopping material used to seal the gaps. The West Hall, North Hall, South Hall and Rehabilitation Hall attic smoke barrier gaps and missing drywall was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/09/15 at 1:00 p.m.</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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient</p>	K 0062	K 62 This finding was not found to have a direct affect on any specific resident. The finding had the potential to have affected all residents of the facility due to the required sprinkler system flush due to be completed. Once the required sprinkler system flush was identified, the Maintenance Manager coordinated with the service vendor to schedule the required service that will be performed beginning 7/27/15 and lasting potentially 2 weeks. The service provider (Indiana Fire Sprinkler & Backflow Inc.) has provided a letter dated 7/16/15 (Attachment A) which reflects a start date for the service (7/27/15) and that a detailed completion notice will be provided to the facility when the work is	08/08/2015

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K 0000	<p>practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 07/09/15 at 9:35 a.m., the most recent sprinkler system internal pipe inspection from Safecare dated 05/23/14 indicated "rust and debris" and recommended a complete flush of the fire sprinkler system. Based on an interview with the maintenance supervisor on 07/09/15 at 9:55 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 05/23/14, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 07/09/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>completed in accordance with NFPA guidelines. The Maintenance Manager will utilize TELS maintenance checklist for LSC compliance in addition to a Life Safety Code binder to maintain documentation for sprinkler system maintenance, inspections, and services completed. Maintenance will document in TELS annually that a review of the sprinkler system inspection records has been completed and when applicable, required sprinkler service and or task completion. The Executive Director will review the TELS checklist and audit sprinkler service records x 2 months to verify sprinkler system flush completion. Audit findings will be reviewed in facility QA&A committee meeting.</p>	

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Bldg. 02	<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: 07/09/15</p> <p>Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450</p> <p>At this Life Safety Code survey, Waldron Health and Rehab 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) and 410 IAC 16.2. The 2011 Rehabilitation room addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story Rehabilitation Room addition was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 79 and had a census of 56 at</p>	K 0000	<p>Credible Allegation of Compliance</p> <p>This plan of correction is the facility's Credible Allegation of Compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.</p>	
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K 0062 SS=F Bldg. 02	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden garage and wooden shed which were not sprinkled.</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> <p>Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p>	K 0062	K 62 This finding was not found to have a direct affect on any specific resident. The finding had the potential to have affected all residents of the facility due to the required sprinkler system flush due to be completed. Once the required sprinkler system flush was identified, the Maintenance Manager coordinated with the service vendor to schedule the required service that will be performed beginning 7/27/15 and lasting potentially 2 weeks. The service provider (Indiana Fire Sprinkler & Backflow Inc.) has provided a letter dated 7/16/15 (Attachment A) which reflects a start date for the service (7/27/15) and that a detailed completion notice will be provided to the facility when the work is completed in accordance with NFPA guidelines. The	08/08/2015

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	<p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 07/09/15 at 9:35 a.m., the most recent sprinkler system internal pipe inspection from Safecare dated 05/23/14 indicated "rust and debris" and recommended a complete flush of the fire sprinkler system. Based on an interview with the maintenance supervisor on 07/09/15 at 9:55 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 05/23/14, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 07/09/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>Maintenance Manager will utilize TELS maintenance checklist for LSC compliance in addition to a Life Safety Code binder to maintain documentation for sprinkler system maintenance, inspections, and services completed. Maintenance will document in TELS annually that a review of the sprinkler system inspection records has been completed and when applicable, required sprinkler service and or task completion. The Executive Director will review the TELS checklist and audit sprinkler service records x 2 months to verify sprinkler system flush completion. Audit findings will be reviewed in facility QA&A committee meeting.</p>		