

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2013
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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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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: 01/28/13</p> <p>Facility Number: 000559 Provider Number: 155719 AIM Number: 100267170</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, George Ade Memorial Health Care 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 II (222) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, spaces open to the corridors and in resident rooms. The facility has a</p>	K0000	<p>February 12, 2013</p> <p>Miriam Buffington, Enforcement Manager Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, IN 46204-3006</p> <p>Re: Survey Event ID: LR7C21</p> <p>Dear Miriam:</p> <p>This letter is in regards to the January 28, 2013 Life Safety Survey conducted at George Ade Memorial Health Care Center, Brook, IN.</p> <p>The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that the facility is in substantial compliance as of the 12 th of February, 2013. At this time we are requesting that the information submitted for this plan of correction is sufficient for a paper compliance review. We would request that the compliance date serve as our date to clear the survey findings and to stop any and all proposed or implemented remedies that</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>capacity of 70 and had a census of 57 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>		<p>have been presented to date.</p> <p>If you have any questions or need further information, call 219-275-2531 or fax 219-275-7472, and we would be available to assist you.</p> <p>Thank you,</p> <p>W R Scott James, HFA GAMHCC</p> <p>c: survey file The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licenser of the long term care</p>		

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			facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.		

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K0025 SS=E	<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 observation and interview, the facility failed to ensure openings through smoke barriers in 3 of 6 smoke compartments were protected to maintain the 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 that 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 could affect visitors, staff and 4 or more residents in the A, B and F smoke compartments which include the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/28/13 at</p>	K0025	<p>The indicated wall has been sealed and the gap closed so as to prevent further concern.</p> <p>Firewall and barrier walls have all been checked for any gaps, proper sealing and filling has been completed as needed.</p> <p>As a preventative measure at the time work is done repairing the penetration of the barrier wall, sealing and filling will be done immediately so as to prevent exposure.</p> <p>The Maintenance Supervisor and/or assistant will be responsible to see that this is checked and maintained on an ongoing basis.</p> <p>This is done as of 1/29/2013.</p>	01/29/2013	

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	<p>11:50 a.m., the smoke barrier fire wall above the lay in ceiling near dietary was sealed between the corrugated roof deck and cement block wall by brick and cement. Two bricks had half inch holes which were not sealed and the cement had crumbled and fallen away leaving gaps of one half to one inch. The maintenance director acknowledge at the time of observation, the wall was incompletely sealed.</p> <p>3.1-19(b)</p>			

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K0029 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 1 of 8 doors to hazardous areas such as a laundry larger than 100 square feet closed automatically or upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in the laundry and activities smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/28/13 at 2:00 p.m., the self closing corridor door to the laundry stood open. The maintenance director said at the time of observation, it was a feature of the self closer that the door would stand open if pushed wide open. He said it would not self close upon activation of the fire alarm and had to be pushed to close.</p>	K0029	<p>The indicated door to the laundry room has been repaired and now closes properly with no gaps or closing restrictions.</p> <p>Common area smoke/fire doors have been checked and adjusted to close properly if needed.</p> <p>Common area smoke/fire doors are checked regularly and adjusted as needed so as to assure proper action and closing.</p> <p>The maintenance supervisor and or assistant will check and repair doors as needed to assure proper operation is maintained.</p> <p>This is done as of 1/29/2013.</p>	01/29/2013			

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K0046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 9 of 9 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and test records with the maintenance director on 01/28/13 at 3:10 p.m., the record identified as evidence for documenting 30 second monthly and 1 1/2 hour annual tests of the battery powered emergency lighting fixtures located in the facility was limited to a single entry for all fixtures each month. The maintenance director said at the time of record review no entry was made for the specific function of each device.</p>	K0046	<p>Proper documentation is now maintained for the emergency lighting. The lights are now identified and the checks documented on the current check off sheet. Prior checks showed only lighting, not each as checked.</p> <p>Emergency lighting is checked and maintained in proper working order. Each light is identified so that maintenance and repair can be monitored and documented.</p> <p>Monitoring and repair will be maintained by the maintenance department.</p> <p>This is done as of 1/29/2013.</p>	01/29/2013			

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K0062 SS=F	<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 observation and interview, the facility failed to ensure a supply of at least two spare sprinkler heads was kept on the premises in a cabinet for each type of sprinkler head installed for the protection of 57 of 57 residents. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice affects visitors, staff and all residents</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/28/13 at 12:15 p.m., spare sprinkler heads were located in a cabinet in the mechanical room housing the sprinkler system. Side wall sprinkler heads were not found in the cabinet. Sidewall sprinkler heads were observed in every resident room during</p>	K0062	<p>Additional sprinkler heads have been secured so as to have the proper type and number for each style/type of sprinkler head on the system.</p> <p>The sprinkler head cabinet has been checked and replacements for the type of sprinkler heads used are maintained to meet the requirement. For when a sprinkler head is used, a replacement will be supplied to maintain the needed number to maintain compliance.</p> <p>Maintenance department will maintain the sprinkler head cabinet along with the inspection provider so as to have proper type and quantity of sprinkler head on hand at all times.</p> <p>This is done as of 2/12/2013.</p>	02/12/2013			

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	<p>the tour with the maintenance director on 01/28/13 between 12:00 p.m. and 3:00 p.m. The maintenance director acknowledged at the time of observations, there were no spare sidewall sprinkler heads to ensure all types of sprinklers in the facility were included in the spare supply.</p> <p>3.1-(19)b</p>			

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K0064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchens was provided with a K-class fire extinguisher. NFPA 101 at 19.3.5.6 refers to 9.7.4.1. LSC 9.7.4.1 states portable fire extinguishers shall be installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, 3-7.1 says K-Class fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats). This deficient practice could affect visitors and 4 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation on 01/28/13 at 12:35 p.m. with the maintenance director, the kitchen was not provided with a K-class fire extinguisher. The maintenance director said at the time of observation, the fire extinguisher contractor had taken it out for service "about two weeks ago" and had not provided a substitute or returned the extinguisher.</p> <p>3.1-19(b)</p>	K0064	<p>The portable fire extinguishers cited are now in place, in the dietary department. This was done as of 1/29/2013.</p> <p>The extinguishers are checked on a monthly basis. Replacements for these are available whenever service is needed to maintain proper coverage.</p> <p>The maintenance department checks the equipment monthly to maintain proper coverage; service provider is to provide additional equipment whenever needed to maintain compliance.</p> <p>This is done as of 1/29/2013.</p>	01/29/2013			

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