

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
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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: 02/14/14</p> <p>Facility Number: 004550 Provider Number: 155736 AIM Number: 200526450</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mill Pond Health Campus 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 located on the south end of a one story building determined to be of Type V (111) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in</p>	K010000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the annual Recertification and State Licensure Survey (ID MDFU11) on December 18, 2013. Please accept this plan of correction as the provider's compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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K010018 SS=E	<p>spaces open to the corridors. The facility has a capacity of 68 and had a census of 45 at the time of this survey.</p> <p>All areas where the 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 02/20/14.</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 Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 36 sleeping rooms was equipped with a latch which latched into the door frame. This deficient practice affects staff, visitors and 10 or more residents on the 200 hall.</p> <p>Findings include:</p>	K010018	Latching device on door separating resident room 204 from corridor was adjusted and tested by Director of Plant Operations on 2/16/2014 to ensure the door would be held tightly in the door frame. Director of Plant Operations/ designee will test latching devices daily x 4 weeks and then monthly x 5 months to ensure	03/16/2014

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K010044 SS=E	<p>Based on observation with the environmental services supervisor and unit manager on 02/14/14 at 12:50 p.m., the door separating resident room 204 from the corridor failed to latch into the door frame when tested twice. The environmental services supervisor acknowledged at the time of observation, the latch was not working to hold the door tightly in the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation.</p>	K010044	<p>latching device working properly. Director of Plant Operations will document all findings. Findings will be reviewed in Quality Assurance meeting monthly x 6 months.</p> <p>The fire door between Health Center and Assisted Living was adjusted by Director of Plant Operations on 2/26/2014 to ensure the door would provide positive latching when released from its magnetic holder and/or upon activation of the fire alarm system. Director of Plant Operations/designee will check door daily x 30 days and then monthly during fire drills x 5 month to ensure door is latching properly. All finding will be documented. Documented findings will be reviewed monthly</p>	03/16/2014			

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	<p>This deficient practice could affect visitors, staff, and 10 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the environmental services supervisor and unit manager on 02/14/14 at 12:30 p.m., the fire door set providing separation between the health care and assisted living occupancies was tested twice. One door in the fire door set failed to latch each time the doors were released from their magnets and allowed to close. The door failed to latch again at 3:25 p.m. when the fire alarm was activated. The environmental services supervisor agreed at the times of observation, there was a problem with the latching mechanism.</p> <p>3.1-19(b)</p>		x 6 months during monthly Quality Assurance meetings.		

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K010050 SS=F	<p>NFPA 101 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 ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Record of Fire Drills with the environmental services supervisor and unit manager on 02/14/14 at 3:40 p.m., there was no record of a first shift fire drill during the fourth quarter of 2013. The environmental services supervisor said at the time of record review, all fire drill records for the past year had been provided.</p> <p>3.1-9(b) 3.1-51(c)</p>	K010050	<p>The fire drill scheduled for first shift during the fourth quarter of 2013 was inadvertently missed due to the absence of Director of Plant Operations. Since that time the fire drills have been conducted quarterly on each shift as per Life Safety regulation. Fire drill will be conducted on each shift quarterly by Director of Plant Operations/designee. All fire drills will be documented. Documentation of fire drills will be reviewed monthly x6 month during Quality assurance meeting to ensure that fire drills conducted per Life Safety regulation.</p>	03/16/2014			

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors, staff and 10 or residents in the library and physical therapy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the environmental services supervisor and unit manager on 02/14/14 at 2:00 p.m., an electric fireplace was plugged into the wall of the library. The glass doors were open and a fan blew warm air into the room. There was nothing on the unit which indicated the temperature limits of the heating element. During a review of facility policies with the environmental services supervisor and</p>	K010070	<p>Electric fireplace plugged into wall of library was unplugged and disabled from further use on 2/16/2014 by Director of Plant Operations. Specifications for fireplace have been located and are on site at this time. Director of Plant Operations/Designee will check fireplace daily x 30 days and then monthly x 6 months to ensure fire place remains disabled. Findings will be documented. Documented findings will be reviewed monthly x 6 months during Quality Assurance meeting.</p>	03/16/2014

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K010072 SS=F	<p>unit manager on 02/14/14 at 3:20 p.m., no policy was found to govern the use of space heaters such as the fire place. The environmental services supervisor said at the time of record review, she had no evidence the fireplace heating element would not exceed the 212 F degree limit and she was unable to provide a policy for the use of space heaters.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 4 of 7 exterior exit discharges were maintained to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 10 or more residents on 200 and 300 halls and</p>	K010072	Plant Operations Support cleared snow from all exits of snow on 2/16/2014 Contractor for snow removal has be advised to clear all exits and sidewalks during snow removal of parking lots. Director of Plant Operations/designee will monitor and clear snow/ice from all egress paths during adverse weather conditions.	03/16/2014

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	<p>in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the environmental services director and unit manager on 02/14/14 between 11:45 a.m. and 3:30 p.m., the exterior emergency exit discharges serving the 300 hall resident room sleeping wing and the main dining room were covered with more than four inches of snow and appeared not to have been cleared before the snow which was falling at the time of survey. The exit discharge for the 200 hall had areas of ice and a layer of new fallen snow which accumulated to approximately two inches during the survey. The environmental services director acknowledged at the time of observations the exterior discharge surfaces for the main dining room and 300 hall appeared not to have been cleared recently. She said an outside contractor was paid to clean the exit discharges and acknowledged it appeared the contractor had chosen to clear those conveniently located to the parking lots. She also acknowledged the discharge for the 300 hall should have been cleared kept free of the ice and snow to allow for safe evacuation. At 4:00 p.m. on 02/14/14 physical therapy staff # 1 reported falling on the snow</p>			
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K010147 SS=F	<p>covered sidewalk leading from the main entrance to the parking lot.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring on 2 of 3 resident sleeping room wings. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents on the 100 and 200 halls.</p> <p>Findings include:</p> <p>Based on observation with the environmental services supervisor and unit manager on 02/14/14 between 11:45 a.m. and 3:30 p.m., power strip extension cords were plugged into outlets on the wall at the head of resident beds and run along the wall to power televisions and other equipment</p>	K010147	<p>All power strips was removed from rooms 103, 107, 108, 109, 112, 113, 204 and 207 on 2/18/2014 per Director of Plant Operations. Facility ensured that only medical equipment was plugged into outlets on wall at head of residents beds.Plant Operations Support contacted an electrician to assess and install additional receptacles in rooms 103, 107, 108, 109, 112, 113, 204 and 207. All rooms will be audited weekly x 3 months and then monthly x 3 months per Director of Plant Operations/Designee to ensure that there is no usage of power strips and that only medical equipment is plugged into outlets.All audits will be reviewed monthly in Quality Assurance meeting x 6 months.Ladder, straight backed chair and hand cart was removed on 2/16/2014 per Plant Operations Support from are cordoned off with tape to ensure there was a 36 inch space, free from obstruction, to access the emergency generator</p>	03/16/2014

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	<p>located on the opposite wall in resident rooms 103, 107, 108, 109, 112, 113, 204 and 207. The environmental services supervisor said at the time of observations, there were no outlets available to plug in equipment located on the wall opposite the beds where televisions and other equipment were located for resident use.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 6 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice could affect all occupants who are served by the proper function of the emergency generator.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>panels. Director of Plant Operations/Designee will audit daily x 30 days then weekly x 8 weeks and then monthly x 3 months to ensure that areas to access the emergency generators panel is free of obstruction. All audits will be reviewed monthly in Quality Assurance meeting x 6 months.</p>				

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	<p>environmental services supervisor and unit manager on 02/14/14 at 12:15 p.m., the emergency generator electrical transfer switch and circuit panels had yellow tape marking the floor three feet from the panels to indicate the areas to be kept free of obstructions. A ladder, straight backed chair and hand cart were stored adjacent to the electrical equipment inside the area cordoned off with tape. The environmental services supervisor acknowledged at the time of observation, the equipment would have to be moved in order to access these emergency generator panels.</p> <p>3.1-19(b)</p>			