

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155600	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/21/2014
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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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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: 04/21/14</p> <p>Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mulberry Health &amp; 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) 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 was fully sprinklered. The facility has a fire alarm system with Hard wired smoke detection in the corridors and spaces open</p>	K010000		
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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>to the corridors. Resident rooms in the original building are equipped with battery powered smoke detectors. The facility has a capacity of 159 and had a census of 132 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. An attached records storage building was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/28/14.</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 in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the</p>			

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	<p>closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 8 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 30 or more residents in the administrative wing which is open to the main dining room and activities area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/21/14 at 12:30 p.m., the door protecting the corridor opening from the conference room had no automatic latch to keep the door closed. The door was equipped with a deadbolt latch which would have to be operated manually to secure the door into the frame. The maintenance director acknowledged at the time of observations, the door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p>	K010018	No residents were affected and no negative outcomes have occurred as a result of the alleged deficient practice. Maintenance staff will add a door knob to the conference room door to ensure positive latch occurs when closed. Maintenance Supervisor will monitor during monthly rounds.	05/21/2014			

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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 Based on observation and interview, the facility failed to ensure the means of egress through 4 of 6 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 20 or more residents on the 200 and 300</p>	K010038	<p>No residents were affected and no negative outcome occurred as a result of the alleged deficient practice. The facility will post the codes at all exist in a #12 font. Maintenance Supervisor will monitor monthly during routine rounds to ensure the codes are posted at all exists.</p>	05/21/2014

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	<p>Wings.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 04/21/14 between 11:30 a.m. and 12:10 p.m., emergency exit doors from the 200 and 300 Wings were magnetically locked. The Maintenance Director demonstrated the locks would release by entering a code on a keypad located on the wall adjacent to the locked doors. The code was not posted at the door near room 325. Codes posted on the mag locks near rooms 313, 212, and 225 were printed in a tiny font which could not be read easily. The Maintenance Director said at the time of observations, the tiny font was to prevent residents from using the codes to open the doors. The Maintenance Director confirmed with the Unit Manager at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated.</p> <p>3.1-19(b)</p>						

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K010050 SS=C	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure all elements of fire drills were included on documentation of fire drills for 4 of the past 4 quarters including the date and time the drill was conducted. LSC 19.7.1.2 requires fire drills in health care facilities shall include the use of alarms, transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Log(s) for the past year with the Maintenance Director on 04/21/14 at 2:25 p.m., fire drill documentation did not include the use and transmission of the alarm, isolation of fire and the fire conditions</p>	K010050	<p>No residents were affected and no negative outcome occurred as a result of the alleged deficient practice. The documentation of fire drills has been completed according to the instruction of this surveyor over 5 years ago, and has sufficed in meeting this requirement for every survey since.</p> <p>The facility will develop a policy and procedure for completing fire drills that meets the new expectations of the surveyor for documentation. Maintenance supervisor will monitor monthly for compliance.</p>	05/21/2014			

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K010062 SS=C	<p>simulated. The record was titled, "Inservice Training" with the Topic, "Fire Drill" and included Presenter, Date, Start/End Time and Attendee's/Title. The Maintenance Director acknowledged at the time of record review, the fire drill documentation did not include all required fire drill elements.</p> <p>3.1-19(b) 3.1-51(c)</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>1. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 2 of 8 smoke compartments were maintained. This deficient practice could affect all staff, visitors and residents.</p>	K010062	No residents were affected and no negative outcome occurred as a result of the alleged deficient practice. The sprinkler heads were always functional. The escutcheons referenced in the survey are only cosmetic in nature and serve no	05/21/2014

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/21/14 between 11:30 a.m. and 2:30 p.m., sprinkler head escutcheons were missing, improperly installed, displaced and/or sprinkler heads were missing leaving a gaps into the attic above:</p> <p>a. The escutcheon was missing from the sprinkler head in the 100 Wing electrical room leaving a two inch annular gap;</p> <p>b. The escutcheons was missing from one of two sprinkler heads in the physical therapy office leaving a half inch annular gap.</p> <p>The Maintenance Director acknowledged at the time of observations, the escutcheons should have been in place as part of the sprinkler installation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler heads in the laundry were free of foreign materials such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects visitors and 2 or more laundry staff.</p>		<p>purpose in the functionality of the sprinkler head.</p> <p>The decorative escutcheons referenced in the survey will be adjusted by the maintenance supervisor to provide a more appealing look. Maintenance Supervisor will monitor monthly during rounds to ensure all escutcheons are fully extended to the ceiling for cosmetic appeal. The sprinkler heads in Laundry will be dusted off, and the Environmental Service Manager will monitor monthly for compliance.</p>	

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K010069 SS=D	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/21/14 at 1:40 p.m., six sprinkler heads in the laundry were covered with a gray fuzzy grime. The Maintenance Director acknowledged at the time of observation, the sprinkler heads were not clean.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to provide the minimum protection between 2 of 2 commercial cooking appliances in the kitchen. NFPA 96, 9-1.2.3 requires deep fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment except where a steel or tempered glass baffle plate is installed at a minimum of eight inches in height between the adjacent appliances. This deficient practice could affect visitors and 4 or more kitchen staff.</p> <p>Findings include:</p> <p>Based on observation of the commercial cooking appliances in the kitchen with</p>	K010069	<p>All residents had the potential to be affected and no negative outcome occurred as a result of the alleged deficient practice.</p> <p>The facility will permanently affix a divider between the fryer and the stove that is a minimum of eight inches in height.</p>	05/21/2014			

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K010076 SS=E	<p>the Maintenance Director on 04/21/14 at 12:50 p.m., the minimum separation of 16 inches, or separation by a steel or tempered glass baffle plate installed at a minimum of eight inches in height, was not provided between the gas range and fryer which were located side by side. The Maintenance Director said at the time of observation, he was unaware the four inch steel plate provided did not meet the minimum requirements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure oxygen stored in 2 of 2 sprinklered oxygen storage areas was properly separated from combustibles. NFPA 99, 8-3.1.11.2(c)2 requires the minimal separations from oxygen and combustibles in a sprinklered building be 5 feet. This deficient practice affects staff, visitors and 40 or more</p>	K010076	All residents residing on the units identified in the survey had a potential to be affected, and no negative outcome occurred as a result of the alleged deficient practice. The areas referenced in the survey were also cited in our 2011 LSC survey referencing the need to elevate the electrical switches and remove a pocket door, which the	05/21/2014			

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K010130 SS=C	<p>residents in the 300 hall and 400 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/21/14 between 11:50 a.m. and 12:35 p.m., three or more 181 Liter capacity liquid oxygen supply containers were stored in a bathroom on the 200 hall and 300 hall. In each of these oxygen supply storage rooms, a tall trash can was located less than five feet from the stored oxygen containers. The cans were used for the disposal of paper products and observed to be at least half full. In addition, the toilet paper rolls were installed in holders on the wall which were also located less than the minimum five feet permitted between combustibles and the stored oxygen containers. The Maintenance Director acknowledged at the time of observations, the combustibles were too close to the oxygen supply.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to provide complete monthly documentation for testing 69 of 69 battery powered smoke detectors.</p>	K010130	<p>facility complied with. The surveyor never referenced the paper products in the 2011 survey, nor the two surveys she has completed since then.</p> <p>The facility will no longer use these locations for oxygen storage</p> <p>No residents had the potential to be affected as the facility did test all smoke detectors weekly, and complete sufficient documentation</p>	05/21/2014			

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	<p>LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice affects visitors, staff, and 110 residents in the 100, 200 and 300 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on a review of the Smoke Alarm Week Check List Battery Check with the Maintenance Director on 04/21/14 at 2:20 p.m., the documentation for the weekly inspection of battery powered smoke detectors was incomplete. The record noted, "100 Wing All, 200 Wing All , and 300 Wing All" at the head of the column for each wing and a date listed for each week of the month. Three other columns for each hall had the heading, "Battery Replace." The Maintenance Director said the first three columns meant all the battery powered smoke detectors had been checked and were in working order. The second columns were for the documentation of battery replacement. One line for all three halls in the replacement columns for September 2013 noted "replace 10" in each column. One week for the battery checks noted, "10." The Maintenance Director acknowledged at the time of record review, the "10" in each battery</p>		<p>of their efforts.</p> <p>The facility will develop a policy that clearly explains the frequency, and way in which it is documenting the smoke detector testing so that the surveyor can understand. This will be monitored monthly by the Maintenance Supervisor.</p>	

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K010143 SS=E	<p>check column could be mistaken for another date or that 10 smoke detectors had batteries replaced. He acknowledged a list with each smoke detector would provide evidence when each of the detectors were checked, had a battery replacement or other maintenance.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 2 of 2 oxygen transfer sites were separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction and identified as an oxygen transfer site. This deficient</p>	K010143	All residents residing on the units identified in the survey had the potential to be affected. No negative outcome occurred as a result of the alleged deficient practice. The facility will no longer use this location as an oxygen transfer area.	05/21/2014			

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	<p>practice affects staff, visitors, and 40 or more residents in the 200 hall and 300 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/21/14 between 11:50 a.m. and 12:35 p.m., three or more 181 Liter capacity liquid oxygen supply containers were stored in a bathroom on the 200 hall and 300 hall. The rooms were identified by the maintenance director as the oxygen supply and transfer rooms for these units. He said the toilet in each room was limited for use by staff and visitors and the Unit Manager confirmed these uses at the time of observations. The door separating each of the oxygen transfer rooms from the corridor had a 20 minute fire rating label. A magnetic sign on the door frame identified the rooms as having oxygen within. Nothing identified the rooms as sites for oxygen transfer. The Maintenance Director said at the time of observations a sign was taped to the interior of the doors to identify oxygen transfer was in progress. When staff transferred the oxygen into the portable tanks they were to put the sign on the exterior of the door. He acknowledged at the time of observations, the signs were missing.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155600		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/21/2014	
NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058			
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K020000	<p>3.1-19(b)</p> <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: 04/21/14</p> <p>Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mulberry Health &amp; 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</p>	K020000					

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K020038 SS=E	<p>Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2.</p> <p>The 2004 addition of 14 rooms on the west 400 hall was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms on the 400 hall are equipped with hard wired smoke detectors. The facility has a capacity of 159 and had a census of 132 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. An attached records storage building was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
	NFPA 101 LIFE SAFETY CODE STANDARD			

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	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 10 or more residents on the 400 Wings.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 04/21/14 between 12:30 p.m. and 1:30 p.m., emergency exit doors from the East and West 400 Wings were magnetically locked. The Maintenance Director demonstrated the locks would release by</p>	K020038	<p>No residents were affected and no negative outcome occurred as a result of the alleged deficient practice.</p> <p>The facility will post the codes at all exist in a #12 font. Maintenance Supervisor will monitor monthly during routine rounds to ensure the codes are posted at all exists.</p>	05/21/2014

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K020050 SS=C	<p>entering a code on a keypad located on the wall adjacent to the locked doors. The code was not posted at the doors exiting the East 400 and the West 400 wings. The Maintenance Director confirmed with the Unit Manger at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated. He said the codes had been posted but someone must have removed them.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to ensure all elements of fire drills were included on documentation of fire drills for 4 of the past 4 quarters including the date and time the drill was conducted. LSC</p>	K020050	No residents were affected and no negative outcome occurred as a result of the alleged deficient practice. The documentation of fire drills has been completed according to the instruction of this surveyor over 5 years ago, and has sufficed in	05/21/2014

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	<p>19.7.1.2 requires fire drills in health care facilities shall include the use of alarms, transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Log(s) for the past year with the Maintenance Director on 04/21/14 at 2:25 p.m., fire drill documentation did not include the use and transmission of the alarm, isolation of fire and the fire conditions simulated. The record was titled, "Inservice Training" with the Topic, "Fire Drill" and included Presenter, Date, Start/End Time and Attendee's/Title. The Maintenance Director acknowledged at the time of record review, the fire drill documentation did not include all required fire drill elements.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>meeting this requirement for every survey since.</p> <p>The facility will develop a policy and procedure for completing fire drills that meets the new expectations of the surveyor for documentation. Maintenance supervisor will monitor monthly for compliance.</p>		