

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2013
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NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN 47330
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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: 01/14/13</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Ambassador Healthcare 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 two story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the partial basement, the corridors, spaces</p>	K0000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as of any proceedings and submit these respnses pursuant to our reregulatory obligations.	
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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>open to the corridors excluding the Service Hall lounge, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 100 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the detached storage building and the detached walk in cooler and walk in freezer.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/24/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observations and interview, the facility failed to ensure 1 of 1 basement storage rooms was provided with interior finishes with a flame spread rating of a class A, class B, or class C for a sprinklered building. This deficient practice could affect 26 residents who reside on the South Wing, West Hall in rooms 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, and 313 which is located directly above the basement storage room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 01/14/13 at 10:10 a.m., the sixty five foot by twenty foot basement storage room was not provided with an interior finish and had wooden studs exposed. Based on an interview with the maintenance supervisor and general contractor on</p>	K0015	<p>1. The storage area in the basement under the 300 hall has been dry walled per Life safety guidelines.2.No residents were caused any harm during the time this area was being dry walled.3. There are no exposed wood in the storage area in basement under 300 hall.4. Maintenance will monitor quarterly to ensure all dry wall remains intact and repair as needed. Maintenance to report to quarterly Q.A. Committee of any trends resulting from their inspections.5. 2/13/2013</p>	02/13/2013			

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	<p>01/14/13 at 10:30 a.m., the basement renovation and North Hall addition are currently being constructed and the general contractor indicated the basement storage room is not part of the addition of the North Hall addition and basement renovation project. The lack of an interior finish on the basement storage room walls was verified by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 open use area was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K0017	<p>1. Hardwire smoke detector was installed on 1/15/2013.2. Non Resident area, no residents were affected.3.Koorsen will check smoke detector on their routine visits and repair if needed.4. Maintenance will report to quarterly Q.A. Committee of any issues found by Koorsen during routine visits.5. 2/13/2013</p>	02/13/2013			

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects 44 residents who use the main dining room, which is located adjacent to the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 11:15 a.m. with the maintenance supervisor, the Service Hall lounge across from the kitchen entrance was open to the corridor. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m..</p> <p>3.1-19(b)</p>						

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K0018 SS=E	<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 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 3 of 53 resident room corridor doors on the North Hall and South Hall would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects ten residents who reside in resident room numbers 108, 113, 201, 216, and 308.</p> <p>Findings include:</p> <p>Based on observations on 01/14/13 during a tour of the facility from 8:55 a.m. to 2:20 p.m. with the maintenance supervisor, the corridor doors to resident room 113, resident room 201, and resident room 216 each had a one inch gap along the top and latching sides of the</p>	K0018	<p>1. New hinges was installed on doors 108, 113, 201, 216, & 308 along with adjustments being made to doors to ensure that the doors close and latch.2. A 100% audit was conducted by Maintenance to ensure all doors close and latch, no other doors were found to have issues.3. Maintenance to do monthly checks on doors to ensure that all doors close and latch. Repair immediately any found not to be closing or latching properly.4. Maintenance to report to the quarterly Q.A. Committee of any trends of doors not closing and latching.5. 23/13/2013</p>	02/13/2013			

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	<p>doors. Furthermore, the corridor doors to resident room 108, resident room 201, and resident room 308 failed to latch into the door frames. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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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 observations and interview, the facility failed to ensure 3 of 6 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 66 residents who reside on the South Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 01/14/13 during observations of the attic smoke barriers above the smoke barrier doors from 1:10 p.m. to 2:00 p.m., the following attic smoke barrier walls above smoke barrier doors had penetrations with no fire stopping material or nonrated material used as firestopping:</p> <p>a. The South Hall smoke barrier wall between the South Hall and North Hall had a one foot circular area filled with yellow expandable foam. Based on an interview with the maintenance</p>	K0025	<p>1. All areas were checked and foam was cleaned out and replaced with approved fire proof material.2. Maintenance did a 100% audit of all smoke barriers to ensure all areas are filled with approved fire proof material.3. Maintenance to inspect barriers every 6 months to ensure that approved fire proofing material remains intact.4. Maintenance to keep a sample of fire proofing material for Life Safety. Report to the Q.A. Committee of any issues found during 6 month inspections of smoke barriers.5. 2/13/2013</p>	02/13/2013			

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	<p>supervisor on 01/14/13 at 1:20 p.m., there was no evidence the expandable foam used at the South Hall smoke barrier was a fire rated material.</p> <p>b. The South Hall West smoke barrier wall had a two inch diameter area of drywall missing where a computer cable penetrated the smoke barrier wall.</p> <p>c. The South Hall East smoke barrier wall had two, four inch diameter areas filled with yellow expandable foam. Based on an interview with the maintenance supervisor on 01/14/13 at 1:20 p.m., there was no evidence the expandable foam used at the South Hall East smoke barrier was a fire rated material.</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 the corridor doors to 5 of 24 hazardous areas such as rooms used for storage of combustible items and measuring over 50 square feet in size, gas fired equipment rooms, and laundry rooms over one hundred square feet in size were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 26 residents who reside on the South Hall West, 40 residents who reside on the North Hall, and 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observations on 01/14/13 during a tour of the facility from 8:55 a.m. to 2:20 p.m. with the maintenance supervisor, the door to each of the</p>	K0029	<p>1. Self Closures were installed on the basement storage room, west hall, storage room, North hall shower room, basement laundry room and basement furnace room.2. No resident was affected due to the closures not being place, all byt the North shower room was in construction areas.3. Maintenance will monitor closure to ensure it is working properly quarterly.4. Maintenance will report to the quarterly Q.A. Committee of any trends noted on door closures not working properly.5. 2/13/2013</p>	02/13/2013	

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	<p>following hazardous area rooms lacked a self closing device: the basement storage room which measured thirteen hundred square feet and had combustible storage consisting of eighty seven cardboard boxes of clothing and paper, the West Hall storage room which measured three hundred square feet and had combustible storage consisting of fourteen shelves of cardboard boxes filled with nursing supplies, the central North Hall shower room, where two, seventy five gallon plastic cans were stored with soiled linen, the four hundred fifty square foot basement laundry room, and the gas fueled furnace room in the basement. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0038 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 exit accesses was readily accessible at all times. This deficient practice could affect 66 resident who reside on the South Hall.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 1:30 p.m. with the maintenance supervisor, the South Hall dining room exit was blocked by a dining room table and four chairs. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K0038	<p>1. Table and four chairs were removed from in front of the exit door.2. No resident has been affected by the table and chairs being to close to exit door.3. Housekeeping Supervisor will monitor placement of tables in south dining room to ensure exit stays open.4. Housekeeping Supervisor will inform the quarterly Q.A. Meeting of any trends of tables being moved back in front of exit door. 5. 2/13/2013</p>	02/13/2013			

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K0046 SS=D	<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>1. Based on observation and interview, the facility failed to ensure 2 of 11 basement exits were provided with emergency powered exterior lighting. This deficient practice does not affect any residents, but affects maintenance and laundry staff who use the basement.</p> <p>Findings include:</p> <p>Based on observations on 01/14/13 during a tour of the basement from 9:00 a.m. to 10:20 a.m. with the maintenance supervisor, the two basement exits were not provided with light fixtures outside each exit door. Based on an interview with the maintenance supervisor on 01/14/13 at 9:45 a.m., the two basement exits are not provided with emergency powered lighting. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview; the facility failed to ensure 2 of 5 battery backup lights were tested</p>	K0046	<p>1. The 2 emergency lights in the basement under the 300 hall have been added to the monthly 30 second check list. Emergency lights have been installed to the outside exits.2. Non resident area so no residents were affected.3. Maintenance has added to monthly 30 second check list. Maintenance will check outside lights monthly to ensure they working properly.4. Maintenance to inform quarterly Q.A. Committee of any issues with battery emergency lighting and outside emergency lights.5. 2/13/2013</p>	02/13/2013			

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	<p>monthly and annually for 90 minutes over the past year to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice does not affect any residents, but affects maintenance and laundry staff who use the basement.</p> <p>Findings include:</p> <p>Based on record review on 01/14/13 at 9:15 a.m. with the maintenance supervisor, the Emergency Lighting Log was reviewed and indicated an annual ninety minute test and monthly tests were conducted on three emergency battery backup lights located on the West Hall over the past year. Based on observation on 01/14/13 with the maintenance supervisor during a tour of the basement</p>			

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	<p>from 9:00 a.m. to 10:20 a.m., there were two battery backup lights in the basement corridor at each exit which were not listed on the Emergency Lighting Log. Based on an interview with the maintenance supervisor on 01/14/13 at 9:17 a.m., the two basement exit battery powered backup lights are not tested monthly or annually and not listed on the Emergency Lighting Log. This was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 basement exit corridors was provided with exit and directional signs to indicate the direction of travel to the primary exit. This deficient practice does not affect any residents but affects the maintenance and laundry staff who use the basement.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 9:25 a.m. with the maintenance supervisor, the basement corridor had a sixty five foot long corridor outside the two laundry room doors with no exit and directional signs at the smoke barrier door indicating the direction of travel to the exit. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K0047	<p>1. Exit light was part of new construction, installed 1/21/2013. Directional signs have been posted.2. Non resident area, no residents were affected.3. Maintenance to monitor exit light monthly to ensure that it remains in working order.4. Maintenance to report to quarterly Q.A. Committee of any issues found with exit lighting.5. 2/13/2013</p>	02/13/2013			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panel automatic dialers located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously</p>	K0051	<p>1. Hard wire smoke detector was installed 1/15/2013 in Service Hall electrical hall.2. Non resident area no resident was affected.3. Koorsen to check smoke detector during their inspections.4. Maintenance to inform quarterly Q.A. Committee of any issues found with smoke detectors.5. 2/13/2013</p>	02/13/2013

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	<p>occupied to provide notification of a fire in that location. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 2:10 p.m. with the maintenance supervisor, the fire alarm control panel digital phone dialer which was located in the electrical room in the Service Hall was not electrically supervised by a smoke detector. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 2:20 p.m. exit conference on 01/14/13.</p> <p>3-1.19(b)</p>				

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 5 of 12 fire drills conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the maintenance supervisor on 01/14/13 at 8:55 a.m., the fire drills conducted on 12/4/12 at 1:00 a.m., 10/17/12 at 12:00 p.m., 09/13/12 at 3:30 a.m., 06/27/12 at 11:00 p.m. and 03/06/12 at 5:00 a.m. lacked documentation the fire alarm system was activated during each fire drill. Based on an interview with the maintenance supervisor on 01/14/13 at 9:15 a.m., it was indicated the fire alarm system was not tested during any of the</p>	K0052	<p>1. To ensure that Fire drills are being documented correctly, this facility has adopted the Life Safety fire drill from their web sight. The fire drill on 10/17/2012 was clearly marked that the alarm was sounded at 12 noon. 2. No resident has been affected by not testing the alarm the following day after a silent alarm was done.3. Maintenance will test alarm the following day after a silent alarm to ensure they are in working order.4. Administrator to sign off on all fire drills and will report any issue to the quarterly Q.A. Committee.5. 2/13/2013</p>	02/13/2013

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	fire drills listed above. The lack of fire alarm system transmission during fire drills was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m. 3.1-19(b)				

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K0056 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>1. Based on observation and interview, the facility failed to ensure 2 of 11 corridors converted to quick response sprinklers were equipped throughout with quick response sprinklers which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. 5-3.1.5.2 states when existing light hazard systems are converted to use</p>	K0056	<p>1.All lights in basement have been moved so as not to interfere with sprinkler system. The sprinkler heads in the west storage closet will extended to 6 feet.2. Non resident areas, no residents were affected.3. Maintenance to monitor lights and sprinkler heads to ensure that there is nothing blocking them.4. Maintenance will inform quarterly Q.A. Committe of any trends.5.2/13/2013</p>	02/14/2013			

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	<p>quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed.</p> <p>This deficient practice could affect 40 residents who reside on North Hall and 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observations on 01/14/13 during a tour of facility from 8:55 a.m. to 2:20 p.m. with the maintenance supervisor, the following locations had Ordinary rated sprinklers and Quick Response rated sprinklers in the same locations:</p> <p>a. The North Hall corridor had five metal fuseable link sprinklers and two liquid filled quick response listed sprinklers with a QR on the side of the sprinkler in the same corridor space.</p> <p>b. The West Hall corridor had five metal fuseable link sprinklers and twelve liquid filled quick response listed sprinklers with a QR on the side of the sprinkler in the same corridor space. The sprinklers different classifications of ordinary and quick response sprinklers</p>			

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	<p>were verified by the maintenance supervisor at the time of observations and at the spare sprinkler cabinet located in the 2008 addition Rehabilitation/Ventilator Wing boiler room and West Hall basement boiler room. The lack of sprinklers with the same classification as ordinary or quick response sprinklers in the North Hall and West Hall was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of 12 basement areas were completely sprinklered. This deficient practice could affect 16 resident who reside on the South Hall West, located above the basement.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 01/14/13 from 8:55 a.m. to 2:20 p.m. with the maintenance supervisor, the following basement areas had sprinklers not providing complete coverage because the sprinklers were obstructed from fluorescent light fixtures: The basement maintenance office, the basement maintenance office corridor, basement center exit corridor near the door, the basement center exit corridor in the center of the corridor, the building superintendent office above the desk. This was verified by the</p>			

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	<p>maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 West Hall storage rooms were provided with sprinklers with a minimum spacing of 6 feet. NFPA 13, The Standard for the Installation of Sprinklers at 4-6.3.4 requires sprinklers shall be spaced no less than 6 feet on center. This deficient practice could affect 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 11:00 a.m. with the maintenance supervisor, the West Hall storage room had four sprinklers spaced five feet apart. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>				

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K0062 SS=E	<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 replace 14 of over 300 sprinklers in the facility covered in white paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 26 residents who reside on the South Hall West, located above the basement, and 16 residents who reside on the West Hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 01/14/13 from 8:55 a.m. to 2:20 p.m., the following locations had sprinklers covered with white paint: one sprinkler in the basement laundry storage room near the door, one sprinkler in the basement laundry bleach room, four sprinklers in front of the basement</p>	K0062	<p>1. Sprinkler heads found with paint or of different type in same smoke compartment have been changed. Internal inspection of the dry sprinkler system is not due until 11/2013.2. No resident has been harmed due to paint on sprinkler heads or sprinkler heads being of different types.3. Maintenance will replace any heads that are found to have paint on them or are a different type in the same smoke compartment. Internal inspection of sry sprinkler system will be completed 11/2013.4. Maintenance will inform the quarterly Q.A. Committee of any trends found with sprinkler head issues.5. 2/13/2014</p>	02/13/2013			

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	<p>laundry room dryers, four sprinklers in the West Hall storage room, one sprinkler in the center nurses' station oxygen storage room and three sprinklers in the employee breakroom. The sprinklers covered with white paint were verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 01/14/13 at 9:15 a.m., there was no documentation to indicate an internal inspection of the dry sprinkler system had been conducted in the past five years. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on</p>						

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review, and interview; the facility failed to ensure 2 of 2 areas where smoking was permitted used the metal self closing containers for discarded smoking material and all areas where smoking was permitted were listed on the written smoking policy. This deficient practice could affect 66 residents who reside on the South Hall and 16 residents who reside on the West Hall if a fire occurred outside the exit areas where smoking was permitted.</p> <p>Findings include:</p>	K0066	<p>1. A new smoking policy was written to reflect smoking areas. The Administrator cleaned up all cigarette butts from the areas noted on 2567.2. No resident was affected by not updating the smoking policy or the discarded cigarette butts.3. New Ash trays and flip top metal cans have been purchased for all smoking areas. Staff were in- serviced on 2/8/2013. 4. The Administrator well do weekly checks of all smoking areas to ensure that cigarette butts are being disposed of in the correct containers. Administrator will report to the</p>	02/13/2013			

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	Based on a review of the written smoking policy labeled Ambassador Healthcare Revised Smoking Policy dated 07/11/12 on 01/14/13 at 9:20 a.m. with the maintenance supervisor, the written policy reflected the outside West exit location and East exit location as smoking locations. Based on observation during a tour of the facility on 01/14/13 from 8:55 a.m. to 2:20 p.m. with the maintenance supervisor, the two outside basement exits were being used by staff observed smoking with no metal containers at either location. Furthermore, the kitchen exit had twelve discarded cigarette butts on the ground surface mixed with wooden mulch and on the concrete pad outside the exit door, the South Hall center dining room exit plastic garbage can had fifty unlit cigarette butts mixed with paper and plastic, and the West Hall outside smoking location had one hundred unlit cigarette butts in the plastic garbage can mixed with paper and plastic with an empty metal container with self closing cover. Based on an interview with the maintenance supervisor on 01/14/13 at 10:40 a.m., when asked if the maintenance staff supervised the discarded cigarette butts before throwing them into the plastic trash cans, the maintenance supervisor indicated this was conducted by the staff members who		quarterly Q.A. Committee of any issues regarding smoking areas.5. 2/13/2013				

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	<p>smoke in the facility. The lack of all areas where smoking is permitted as part of the written smoking policy and unsupervised discarded cigarette butts mixed with plastic, paper, and wooden mulch was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to document monthly load tests for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K0144	<p>1. Weekly generator checks were shown to Life Safety, no check marks are found on documentation. The generator panel shows the load % during the test. This issue was not brought to the Administrator during the exit conference.2. No resident has been affected, generator tests were completed and load % documented.3. Maintenance will continue to do weekly generator tests and load % documentation.4. Maintenance will report to the quarterly Q.A. Committee when there is an issue with generator load test.5. 2/13/2013</p>	02/13/2013			

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	<p>Based on a review of the Weekly Generator Check Log with the maintenance supervisor on 01/14/13 at 9:10 a.m., the load tests were documented over the past year on a weekly basis by recording a check mark under a column reading 30% test. Based on an interview with the maintenance supervisor on 01/14/13 at 9:40 a.m., when asked how the thirty percent figure was determined, the maintenance supervisor indicated he did not know. The lack of a documented load test monthly by either documenting a calculated method of the listed thirty percent of the emergency power system's name plate rating or the load being maintained at exhaust gas temperatures was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0147 SS=E	<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>Based on observation and interview, the facility failed to ensure 1 of 38 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 44 residents who use the main dining room in the North Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 01/14/13 at 11:50 a.m., the North Hall main dining room had an electric receptacle on the wall within two feet of the handwash sink</p>	K0147	<p>1. A GFCI plug was installed in North Dining room on 1/15/2013.2. A 100% audit was completed by Maintenance to ensure all plugs near water sources are GFCI plugs. No other were found.3. Maintenance to checks all GFCI plugs quarterly to ensure they are in working order.4. Maintenance will inform quarterly Q.A. Committee of any trend with GFCI Plugs.5. 2/13/2013</p>	02/13/2013

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	<p>with no ground fault circuit interrupter in the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breaker for the electric outlet was not provided with GFCI protection. This was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 92 of 100 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of</p>	K0154	<p>1. A new policy and worksheet was developed so that sprinklers out of service can be documented and to ensure that the ISDH, Fire Dept, Insurance Company and owner have been notified.2. No residents have been affected due to the sprinkler system has not been down for more than 4 hours in 24 hours.3. The Administrator and/or designee will ensure that all parties have been notified of sprinkler system being down for more that 4 hours in a 24 hour period.4. The Adinistrator will report to the quarterrrly Q.A. Committee if sprinkler system is down for more than 4 hours in a 24 hour period and results.5. 2/13/2013</p>	02/13/2013			

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	<p>everyone again when the system is restored. This deficient practice could affect all residents in the original portion of the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/14/13 at 2:10 p.m. with the administrator, the facility's written policy in the event the automatic sprinkler system was placed out of service did not indicate the out of service time frame of four hours or more in a twenty four hour period, and lacked notification of the Indiana State Department of Health, the local fire department, and the insurance carrier. This was verified by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 92 of 100 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/14/13 at 2:10 p.m. with the administrator, the facility's written policy in the event the fire alarm system was placed out of service did not indicate the out of service time frame of four hours or more in a twenty four hour period, and lacked notification of the Indiana State</p>	K0155	<p>1. A new policy and worksheet was developed so that sdprinklers time out oif service can be documented and ensure that ISDH, Fire Dept, Insurance Company and owners have been notified.2. No residents have been affected due to the sprinkler system has not been down for more than 4 hours in a 24 hour period.3. The Administrator and/ or designee will ensure that all parties are notified sprinkler system being down for more than 4 hours in a 24 hour period.4. The Administrator will report to the quarterly Q.A. Committee if sprinkler system is down for more than 4 hours in a 24 hour period and results.5. 2/13/2013</p>	02/13/2013			

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	<p>Department of Health and the local fire department. This was verified by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/14/13</p> <p>Facility Number: 000456 Provider Number: 155490 AIM Number: 100288750</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Ambassador Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The 2008 Rehabilitation Hall was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2008 addition to the one story facility was determined to be of Type V (111) construction and</p>	K0000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as of any proceedings and submit these respnses pursuant to our reregulatory obligations.	

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	<p>was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has the capacity for 137 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the detached storage building and the detached walk in cooler and walk in freezer.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 hazardous areas such as a gas fired equipment room was provided with a self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 8 residents who reside on the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 1:45 p.m. with the maintenance supervisor, the 2008 addition Rehabilitation/Ventilator Wing gas fired hot water heater room door lacked a self closing device. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K0029	<p>1. Self Closures were installed on the basement storage room, west hall, storage room, North hall shower room, basement laundry room and basement furnace room.2. No resident was affected due to the closures not being place, all byt the North shower room was in construction areas.3. Maintenance will monitor closure to ensure it is working properly quarterly.4. Maintenance will report to the quarterly Q.A. Committee of any trends noted on door closures not working properly.5. 2/13/2013</p>	02/13/2013			

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K0044 SS=E	<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 1 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. This deficient practice affects 8 residents who reside on the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 1:30 p.m. with the maintenance supervisor, the Rehabilitation/Ventilator Wing set of fire doors was released from the magnetically held releasing device on two attempts and the set of fire doors failed to latch and close in the door frame. Furthermore, the latching mechanism at the top of the south door was missing. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p>	K0044	<p>1. Maintenance replaced the latch at the top of the fire door on Rehabilitation hall this resolved the issue.2. A 100% audit was done off all fire doors to ensure that they latched when closed, no issues were found.3. Maintenance to do monthly checks to ensure that top latches are in place and fire doors are latching properly.4. Maintenance to report to quarterly Q.A. Committee of any trends noted of fire doors not latching properly.5. 2/13/2013</p>	02/13/2013			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panel automatic dialers located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of</p>	K0051	<p>1. Hard wire smoke detector was installed 1/15/2013 in Service Hall electrical hall.2. Non resident area no resident was affected.3. Koorsen to check smoke detector during their inspections.4. Maintenance to inform quarterly Q.A. Committee of any issues found with smoke detectors.5. 2/13/2013</p>	02/13/2013			

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	<p>a fire in that location. This deficient practice could affect all residents in the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on observation on 01/14/13 at 2:10 p.m. with the maintenance supervisor, the fire alarm control panel digital phone dialer which was located in the electrical room in the Service Hall was not electrically supervised by a smoke detector. Furthermore, the 2008 addition Rehabilitation/Ventilator Wing utilized the fire alarm control panel digital phone dialer which was electrically wired from the 2008 addition to the existing facility. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 2:20 p.m. exit conference on 01/14/13.</p> <p>3-1.19(b)</p>			

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 5 of 12 fire drills conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the maintenance supervisor on 01/14/13 at 8:55 a.m., the fire drills conducted on 12/4/12 at 1:00 a.m., 10/17/12 at 12:00 p.m., 09/13/12 at 3:30 a.m., 06/27/12 at 11:00 p.m. and 03/06/12 at 5:00 a.m. lacked documentation the fire alarm system was activated during each fire drill. Based on an interview with the maintenance supervisor on 01/14/13 at 9:15 a.m., it was indicated the fire alarm system was not tested during any of the</p>	K0052	<p>1. To ensure that Fire drills are being documented correctly, this facility has adopted the Life Safety fire drill from their web sight. The fire drill on 10/17/2012 was clearly marked that the alarm was sounded at 12 noon. 2. No resident has been affected by not testing the alarm the following day after a silent alarm was done.3. Maintenance will test alarm the following day after a silent alarm to ensure they are in working order.4. Administrator to sign off on all fire drills and will report any issue to the quarterly Q.A. Committee.5. 2/13/2013</p>	02/13/2013			

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	<p>fire drills listed above. The lack of fire alarm system transmission during fire drills was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Post Indicator Valves (PIV) for the 2008 addition Rehabilitation/Ventilator Wing was provided with an electrical alarm which alarmed when the valve was closed. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice affects 8 residents who reside on the 2008 addition Rehabilitation/Ventilator Wing if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation of the post indicator valve for the 2008 Rehabilitation/Ventilator Wing, located outside the northeast portion of the addition, the post indicator valve had an electrical box mounted on the side of the</p>	K0061	<p>1. Koorsen was notified of the need for an alarm on post indicator valve.2. No resident has been affected do to the alarm not being on post indicator valve.3. Koorsen to install alarm and will check during their routine inspections.4. Maintenance will report to the quarterly Q.A. Committee of any issues found wit post indicator valve.5. 2/13/2013</p>	02/13/2013			

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	<p>valve but had no electrical wiring inside the box. This was verified by the maintenance supervisor at the time of observation and confirmed by the Administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>Based on observation, record review, and interview; the facility failed to ensure all areas where smoking was permitted were listed on the written smoking policy. This deficient practice could 6 residents on the 2008 addition Rehabilitation/Ventilator Wing who would use the center exit if a fire occurred outside the center exit area where smoking was permitted.</p> <p>Findings include:</p> <p>Based on a review of the written smoking policy labeled Ambassador Healthcare</p>	K0066	<p>1. A new smoking policy was written to reflect smoking areas. The Administrator cleaned up all cigarette butts from the areas noted on 2567.2. No resident was affected by not updating the smoking policy or the discarded cigarette butts.3. New Ash trays and flip top metal cans have been purchased for all smoking areas. Staff were in- serviced on 2/8/2013. 4. The Administrator well do weekly checks of all smoking areas to ensure that cigarette butts are being disposed of in the correct containers. Administrator will report to the</p>	02/13/2013			

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	<p>Revised Smoking Policy dated 07/11/12 on 01/14/13 at 9:20 a.m. with the maintenance supervisor, the written policy reflected the outside West exit location and East exit location as smoking locations. Based on observation during a tour of the facility on 01/14/13 at 1:45 p.m. with the maintenance supervisor, the 2008 addition Rehabilitation/Ventilator Wing Center Hall outside area was being used by staff as a smoking location. Furthermore, this area was not listed in the written policy as a smoking location. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>		<p>quarterly Q.A. Committee of any issues regarding smoking areas.5. 2/13/2013</p>		

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K0067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on observation, record review and interview; the facility failed to ensure 2 of 2 fire dampers located in the 2008 addition Rehabilitation/Ventilator Wing were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 8 residents who reside on the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on observations on 01/14/13 during a tour of the 2008 addition Rehabilitation/Ventilator Wing with the</p>	K0067	.1. We contacted Meyers Mechanical and informed them of the dampers needing inspection.2. No resident has been affected due to dampers being 1 month past inspection date of 12/ 23/ 2008.3. Meyers Mechanical inspected dampers and will put on a routine every 4 year inspection.4. Maintenance will report to the quarterly Q.A. Committee any issues found with the damper inspections.5. 2/13/2013	02/13/2013			

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	<p>maintenance supervisor from 1:20 p.m. to 2:10 p.m., the main lounge and the north lounge each had a fusible link fire damper located in a return air duct. Based on review of the Life Safety Code surveys conducted at the facility on 01/15/13, the 2008 addition Rehabilitation/Ventilator Wing had an initial Life Safety Code Survey date of 12/23/2008, which is a period exceeding the four year inspection requirement. Based on an interview with the maintenance supervisor on 01/14/13 at 1:40 p.m., there are no records to indicate the two fire dampers have been inspected. The lack of a four year fire damper inspection was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure penetrations in 1 of 1 fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item</p>	K0130	<p>1. The fire wall on Ventilator hall was cleared of orange expandable foam and replaced with an approved fire proof material.2. Maintenance did a 100% audit of all fire barriers to ensure areas were filled with an approved fire proof material.3. Maintenance to inspect fire barriers every 6 months to ensure that fire proofing material is intact.4.Maintenance to keep a sample of fire proofing material for Life Safetyty. Report to quarterly Q.A. Committee of any reoccurring issues with fire barriers.5. 2/13/2013</p>	02/13/2013			

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	<p>uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affects 8 residents who reside on the 2008 addition Rehabilitation/Ventilator Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 01/14/13 at 1:30 p.m., the attic fire barrier wall between the existing North Hall and the 2008 addition Rehabilitation/Ventilator Hall had a sprinkler pipe penetration in the center of the fire barrier wall filled with an orange expandable foam product. Based on an interview with the maintenance supervisor on 01/14/13 at 1:40 p.m., there was no evidence the orange expandable foam used at the 2008 addition Rehabilitation/Ventilator Hall fire barrier was a fire rated material. This was confirmed by the administrator at the 2:20 p.m. exit conference on 01/14/13.</p> <p>3.1-19(b)</p>						

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to document monthly load tests for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K0144	<p>1. Weekly generator checks were shown to Life Safety, no check marks are found on documentation. The generator panel shows the load % during the test. This issue was not brought to the Administrator during the exit conference.2. No resident has been affected, generator tests were completed and load % documented.3. Maintenance will continue to do weekly generator tests and load % documentation.4. Maintenance will report to the quarterly Q.A. Committee when there is an issue with generator load test.5. 2/13/2013</p>	02/13/2013
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	<p>Based on a review of the Weekly Generator Check Log with the maintenance supervisor on 01/14/13 at 9:10 a.m., the load tests were documented over the past year on a weekly basis by recording a check mark under a column reading 30% test. Based on an interview with the maintenance supervisor on 01/14/13 at 9:40 a.m., when asked how the thirty percent figure was determined, the maintenance supervisor indicated he did not know. The lack of a documented load test monthly by either documenting a calculated method of the listed thirty percent of the emergency power system's name plate rating or the load being maintained at exhaust gas temperatures was confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0147 SS=E	<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>Based on observation and interview, the facility failed to ensure 3 of 8 resident rooms on the Ventilator Hall did not use flexible cords as a substitute for fixed wiring to provide power for medical electrical devices. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requirest, 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 6 residents who reside on the Ventilator Hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the 2008 addition Rehabilitation/Ventilator Hall with the maintenance supervisor on 01/14/13 from 1:20 p.m. to 2:10 p.m., resident room RH5, RH6, and RH7 used power strip extension cords to power suction machines, electric beds, and oxygen concentrators. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K0147	<p>1. A GFCI plug was installed in North Dining room on 1/15/2013.2. A 100% audit was completed by Maintenance to ensure all plugs near water sources are GFCI plugs. No other were found.3. Maintenance to checks all GFCI plugs quarterly to ensure they are in working order.4. Maintenance will inform quarterly Q.A. Committee of any trend with GFCI Plugs.5. 2/13/2013</p>	02/13/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 01/14/2013	
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K0154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 8 of 100 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of</p>	K0154	<p>1. A new policy and worksheet was developed so that sprinklers out of service can be documented and to ensure that the ISDH, Fire Dept, Insurance Company and owner have been notified.2. No residents have been affected due to the sprinkler system has not been down for more than 4 hours in 24 hours.3. The Administrator and/or designee will ensure that all parties have been notified of sprinkler system being down for more that 4 hours in a 24 hour period.4. The Adinistrator will report to the quarterrrly Q.A. Committee if sprinkler system is down for more than 4 hours in a 24 hour period and results.5. 2/13/2013</p>	02/13/2013			

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	<p>everyone again when the system is restored. This deficient practice could affect all residents who reside on the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on record review on 01/14/13 at 2:10 p.m. with the administrator, the facility's written policy in the event the automatic sprinkler system was placed out of service did not indicate the out of service time frame of four hours or more in a twenty four hour period, and lacked notification of the Indiana State Department of Health, the local fire department, and the insurance carrier. This was verified by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K0155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 8 of 100 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 18.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 18.7.1.2 through 18.7.2.3 shall apply. 18.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 18.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents who reside on the 2008 addition Rehabilitation/Ventilator Wing.</p> <p>Findings include:</p> <p>Based on record review on 01/14/13 at 2:10 p.m. with the administrator, the facility's written policy in the event the fire alarm system was placed out of service did not indicate the out of service time frame of four hours or more in a twenty four hour period, and lacked notification of the Indiana State</p>	K0155	<p>1. A new policy and worksheet was developed so that sdprinklers time out oif service can be documented and ensure that ISDH, Fire Dept, Insurance Company and owners have been notified.2. No residents have been affected due to the sprinkler system has not been down for more than 4 hours in a 24 hour period.3. The Administrator and/ or designee will ensure that all parties are notified sprinkler system being down for more than 4 hours in a 24 hour period.4. The Administrator will report to the quarterly Q.A. Committee if sprinkler system is down for more than 4 hours in a 24 hour period and results.5. 2/13/2013</p>	02/13/2013			

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	<p>Department of Health and the local fire department. This was verified by the administrator at the exit conference on 01/14/13 at 2:20 p.m.</p> <p>3.1-19(b)</p>			