

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155812	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CONCORD ROAD CRAWFORDSVILLE, IN 47933
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/11/15</p> <p>Facility Number: 013107 Provider Number: 155812 AIM Number: NA</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At Life Safety Code survey, Wellbrooke of Crawfordsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies.</p> <p>The certified health care area included all but the south Renaissance unit of a one story facility determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors., Hard wired smoke detectors are installed in all 66</p>	K010000		

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>Comprehensive resident rooms. The facility has the capacity for 70 Comprehensive beds with a census of 37 at the time of this survey.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/17/15.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 1 double door sets separating the kitchen from the emergency exit corridor would resist the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the adjacent corridor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 02/11/15 at 10:10 a.m., double doors protecting the corridor openings to the kitchen gapped 1/4 inch</p>	K010018	<p>Corrective action: contractor notified to adjust the identified door in order to have 1/4" gap on doors, pending arrival of contractor Other residents affected: all residents have potential to be affected, no other doors were identified Systematic changes: monthly door checks will be completed by Director Plant Operations (DPO) or designee on an ongoing basis to ensure exit corridors are resistance to passage of smoke Monitoring: results of the monthly door audit will be brought to monthly QA x 3 months then</p>	03/13/2015

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K010021 SS=E	<p>to one inch at the meeting edges of the doors when closed. The Director of Plant Operations acknowledged at the time of observation, these doors could not resist the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure a door in 1 of 3 200 hall smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of</p>	K010021	<p>quarterly unless otherwise noted by the IDT QA team DOC: 3-13-15</p> <p>Corrective action: contractor notified to adjust the identified door in order to allow it to close upon activation of fire alarm system, pending arrival of contractor Other residents affected: all residents have potential to be affected, no other doors were identified Systematic changes: monthly door checks will be completed by Director Plant Operations (DPO) or designee on an ongoing basis to ensure identified doors will close upon activation of the fire alarm system. In addition, the</p>	03/13/2015	

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K010022 SS=E	<p>Plant Operations on 02/11/15 at 11:30 a.m., one door in the smoke barrier double door set located near room 203 failed to close and left a four inch gap when tested twice to ensure its proper operation. The door was again observed with the activation of the fire alarm system on 02/11/15 at 11:35 a.m. and the same door failed to close leaving the four inch gap. The Director of Plant Operations acknowledged at the time of observations, the door was not closing to prevent the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 4 paths in the exit means of egress from the 100 hall was clearly identified. This deficient practice affects visitors, staff and 10 or more residents on the 100 hall.</p> <p>Findings include: Based on observation with the Director of Plant Operations on 02/11/15 at 11:45</p>	K010022	<p>identified and like doors will be reviewed during monthly fire drills on an ongoing basis Monitoring: results of the monthly door audit and fire drills will be brought to monthly QA on an ongoing basis unless otherwise noted by the IDT QA team DOC: 3-13-15</p> <p>Corrective action: Esco has been notified to provide an illuminated "exit" sign above the smoke barrier door separating the east 100 hall from the adjacent smoke compartment Other residents affected: all residents have ability to be affected by identified area, however, no additional exit means of egress identified Systematic changes: all exit means of egress will be reviewed weekly through walking rounds by the</p>	03/13/2015

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K010025 SS=E	<p>a.m., four directions were identified on the evacuation plan posted for the 100 hall. Illuminated exit signs were visible for three directions with no exit sign visible for the east corridor exit way. No illuminated exit sign was located above the smoke barrier door separating the east 100 hall from the adjacent smoke compartment. The vision panels in these door did not provide a view of the exit sign at the end of the east corridor unless one stood within five feet of the doors when closed. The Director of Plant Operations acknowledged at the time of observation, no exit sign was evident to direct residents to the east exit discharge if the doors were closed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings through ceilings in 2 of 3 electrical room ceilings</p>	K010025	<p>DPO to ensure exit is clearly identified/illuminated. Any identified area not in compliance will be corrected immediately. Any identified non-compliance will be brought to monthly QA on an ongoing basis unless otherwise noted by the IDT QA committee Monitoring: all exit means of egress will be reviewed weekly through walking rounds by the DPO to ensure exit is clearly identified. Any identified area not in compliance will be corrected immediately. Any identified non-compliance will be brought to monthly QA on an ongoing basis unless otherwise noted by the IDT QA committee Date of completion: 3-13-15</p> <p>Corrective action: fire retardent barrier has been order to place in the identified area Other residents affected: all residents</p>	03/13/2015			

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	<p>were protected to maintain the smoke resistance of the ceiling smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 10 or more residents in the 100 and the center smoke compartment on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 02/11/15 between 10:30 a.m. and 2:30 p.m. ceiling smoke barriers in the 100 hall and 200 hall had cutouts of two by eight, two by four, two by sixteen, four by twenty four and four by thirty six inches in the ceiling to allow for the passage of electrical conduit. The Director of Plant Operations acknowledged at the times of observation the gaps would allow the passage of smoke into the interstitial space above the ceilings and should have been sealed with a fire rated material.</p> <p>3.1-19(b)</p>		<p>have the potential to be affected, however, no other areas were identified Systematic changes: by adding the permanent fire retardent barriers, permanent barriers that will not need to be added. As a preventative maintenance measure, quarterly checks will be completed to ensure fire retardent barrier remains in place x 1 year. Any altercation to this PM check will be consulted with home office plant operations support for change in direction if needed Monitoring: DPO will provide the quarterly checks to ensure the fire retardent barriers remain in place x 1 year. Home office plant operations support will provide direction at the end of the 1 year review to determine if further monitoring will be required. The quarterly checks will be brought to QA quarterly unless otherwise determined by the IDT QA committee Date of completion: 3-13-15</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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure records of fire drills conducted quarterly on each shift were complete for 2 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's monthly Fire Drill Reports and interview with the Director of Plant Operations on 02/11/15 at 1:35 p.m., records for second shift drills conducted during the first and second quarters of 2014 failed to include the times the drills were done. Additionally the Fire Drill Reports left</p>	K010050	<p>Corrective action: monthly fire drills were completed, however, we cannot go back to correct the 2 missing times of the fire drills. Moving forward, we will ensure times have been included on all fire drill reports Other residents affected: all residents have the potential to be affected, no other fire drills were identified</p> <p>Systematic changes: ED will sign off and review all fire drill reports to ensure time is noted on the report on an ongoing basis.</p> <p>Monitoring: ED will sign off and review all fire drill reports to ensure time is noted on the report on an ongoing basis. DPO will bring fire report information to monthly QA on an ongoing basis to ensure compliance unless otherwise noted by the IDT QA committee Date of completion:</p>	03/13/2015

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K010062 SS=F	<p>blank the verification of the receipt of the alarm by the monitoring station where indicated. The Director of Plant Operations acknowledged at the time of record review there was no way to determine what time the drills were done.</p> <p>3.1-9(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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 3 of 4 quarters. LSC 4.6.12. requires maintenance and testing of the automatic sprinkler system are made at specified intervals in accordance with applicable NFPA standards. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires that waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires that the priming level shall be tested quarterly.</p>	K010062	<p>3-13-15</p> <p>Corrective action: B & R notified of the missing sprinkler inspections Other residents affected: all residents have the potential to be affected, B & R visit scheduled for 2/26/14 and has been placed on quarterly schedule. Systematic changes: DPO has ordered an annual calendar to reflect when quarterly inspections are due (quarterly sprinkler inspections have been added to the calendar). ED will review Life Safety Code binder that contains inspections no less than quarterly ongoing. Monitoring: DPO has ordered an annual calendar to reflect when quarterly inspections are due (quarterly sprinkler inspections have been added to the calendar). ED will review Life</p>	03/13/2015			

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	<p>NFPA 25, 9-7.1 requires that the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires that records shall indicate the procedure performed (inspection, test, or maintenance), the organization that performed the work, the results and the date. Finally, NFPA 25, 1-8 requires that records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on a review of Fire Sprinkler inspection reports with the Director of Plant Operations on 02/11/15 at 12:40 p.m., no quarterly sprinkler inspections for the first and second quarters of 2014 were found. The Director of Plant Operations immediately called the sprinkler system inspection contractor but the missing reports were not forthcoming by the time of the survey's conclusion. A subsequent email sent by the Director of Plant Operations on 02/11/15 provided missing documentation but did not</p>		<p>Safety Code binder that contains inspections no less than quarterly ongoing to assist in monitoring. Fire related inspectiions will be brought to monthly QA on an ongoing basis for review unless otherwise noted by the IDT QA committee Date of completion: 3-13-15</p>		

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K010144 SS=F	<p>include a second quarter (June, July August for this facility) sprinkler inspection report. A follow up call to the Director of Plant Operations confirmed there had been no other sprinkler inspections.</p> <p>3.1-19(b)</p> <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>1. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 99, 3-5.4.2</p>	K010144	<p>Corrective action: weekly generator tests have been added to the preventative maintenance schedule Other residents affected: all residents have the potential, nothing further identified with this deficient practice</p> <p>Systematic changes: weekly generator tests have been placed on the preventative maintenance schedule. Weekly testing will be conducted every Wednesday @ 11:00 am unless otherwise determined or changed for efficiency by the DPO</p> <p>Monitoring: DPO will monitor weekly generator tests through the preventative maintenance schedule. Weekly generator tests will be brought to monthly QA x 3 months then quarterly on an ongoing basis unless otherwise noted by the IDT QA committee Date of completion:</p>	03/13/2015

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	<p>requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Emergency Generator test records with the Director of Plant Ops on 02/11/15 at 2:40 p.m., no documentation of weekly battery inspections for the emergency generator were found for the past year. The Director of Plant Ops said at the time of record review, he did checked the battery each month when he transferred the load but made no documentation of weekly checks.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, the Standard for Health Care Facilities, 3-4.4.1.1(a) requires that monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency</p>		3-13-15				

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	<p>and Standby Power Systems. NFPA 110, 6-4.2 requires that generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Test Generator Under Load records with the Director of Plant Operations on 02/11/15 at 2:40 p.m., the emergency generator was tested monthly under load for 30 minutes with amperage readings for each phase of the three phase generator included. However, no information for the percent load carried during the load testing was not include. The Director of Plant Operations said at the time of record review, he did not know what the percent load carried on the generator during load testing and had not been trained to determine the load based on readings provided.</p>			

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K010147 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 02/11/15 at 11:50 a.m., a nebulizer was plugged into an electric receptacle on a bedside lamp in resident room 216; at 11:55 a.m. a oxygen concentrator was plugged into a table lamp receptacle. The Director of Plant Operations acknowledged the lamp receptacles were another type of</p>	K010147	<p>Corrective action: nebulizer machine was plugged in to appropriate receptacle. Nursing educated at time of tour Other residents identified: rounds were completed to ensure no other oxygen concentrator was plugged into the bedside lamp. No additional residents affected</p> <p>Systematic changes: education provided to nursing personnel related to appropriate plug in of oxygen concentrators. DHS, ADHS or designee will provide rounds no less than 3x/week x 4 weeks then weekly x 4 weeks to ensure oxygen concentrators are plugged into appropriate receptacles. Monitoring: DHS, ADHS or designee will provide rounds no less than 3x/week x 4 weeks then weekly x 4 weeks to ensure oxygen concentrators are plugged into appropriate receptacles. Rounding information will be brought to monthly QA x 2. IDT QA committee will determine at the end of 2nd 4 weeks if continued rounds will be necessary and will note in the QA minutes Date of completion: 3-13-15</p>	03/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155812	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 517 CONCORD ROAD CRAWFORDSVILLE, IN 47933		
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	multiplug adapter and should not have been used for medical equipment. 3.1-19(b)				