

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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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: 03/22/12</p> <p>Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Warsaw Meadows Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211) construction in the original</p>	K0000		

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>building and Type V (111) construction in the northwest, west and laundry wings and all were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The resident rooms are without smoke detection at this time. The facility has a capacity of 100 and had a census of 63 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/29/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any resident near the storage/housekeeping room and the water heater room on the Memory hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Supervisor on 03/22/12 at 12:45 p.m., there was a one fourth inch hole along side the sprinkler head escutcheon in the ceiling in the</p>	K0025	<p>K 025 1. Maintenance Director has sealed the hole beside side the sprinkler head escutcheon in the ceiling in the storage/housekeeping room on the Memory Hall. He has replaced the foam in the water heater room. 2. Maintenance Director will inspect facility to ensure if any other expandable foam is in use he will replace with the proper material. 3. Maintenance Director will be inserviced on the new audit tool. 4. Maintenance Director will do quality improvement audits to ensure all wholes are sealed properly within facility weekly times four weeks, then monthly thereafter.</p>	04/21/2012

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	<p>storage/housekeeping room on the Memory hall. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>b. Based on observation with the Maintenance Supervisor on 03/22/12 at 12:50 p.m., six penetrations in the water heater room on the Memory hall were sealed with expandable foam. This expandable foam has been used in numerous places at the ceiling smoke barrier throughout the facility. Based on an interview with the Maintenance Supervisor at the time of observation, the expandable foam was flame retardant but he was not aware this material has not been approved for sealing smoke barrier penetrations.</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>1. Based on observation and interview, the facility failed to ensure the corridor door to 2 of 3 hazardous areas, such as a kitchen and rooms with combustibile storage measuring over 50 square feet in size, were provided with a self closing device. This deficient practice could affect any of the 13 residents on Harmony hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Supervisor on 03/22/12 at 12:35 p.m., the corridor door to the Harmony hall accounting storage room with eighty five cardboard boxes of resident records, measuring ninety eight square feet in size,</p>	K0029	<p>K 029 1. Maintenance Director has put the self closing devices on the doors affected and new door has been ordered for the kitchen dish room. The laundry room door has been corrected. 2. No other areas were affected. 3. Maintenance Director will be inserviced on the use of the new audit tool. 4. Maintenance Director will do quality improvement audits to ensure doors are working properly with the self closing devices weekly times four weeks, then monthly thereafter.</p>	04/21/2012			

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	<p>lacked a self closing device. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>b. Based on observation with the Maintenance Supervisor on 03/22/12 at 2:15 p.m., the corridor door entering the kitchen dish room was a hollow door that lacked a self closing device. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sets of corridor doors to the laundry room were positive latching doors. This deficient practice could affect any resident evacuated the the emergency exit near the laundry room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/22/12 at 1:56 p.m., the inactive leaf of the doors entering the laundry room could only be</p>			

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	<p>manually latched into the door frame and the positively latching door would latch into the inactive leaf. This was acknowledged by the Maintenance Supervisor at the time of observation.</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 provide an exit discharge that was readily accessible for 3 of 11 means of egress to a public way. LSC Section 19.2, Means of Egress Requirements, requires every exit discharge, exit location and access shall be in accordance with LSC Chapter 7. LSC 7.1.6.3 requires the means of egress be nominally level. This deficient practice affects all residents evacuated through the Therapy hall, Primrose north and northeast exits in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/22/12 from 1:12 p.m. to 1:16 p.m., a three feet by three feet section of the asphalt sidewalk near the Primrose northeast exit is sinking, deteriorating and breaking apart from the sidewalk. This is creating a trip hazard. Additionally, at the Primrose north</p>	K0038	K 038 1. Asphalt sidewalk near the Primrose northeast exit has been repaired. 2. No other areas were affected. 3. Maintenance Director will be inserviced on the use of the new audit tool. 4. Maintenance will to quality improvement audits weekly times four weeks, then monthly thereafter to ensure asphalt is not cracking.	04/21/2012

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	<p>exit there is a two inch grade change where the asphalt meets the concrete creating a trip hazard. Finally, there was an area of asphalt broken up ten inches from the Primrose north exit. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>			

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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. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 pocket fire doors was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect any occupant in the administration corridor in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/22/12 at 12:12 p.m., the administration corridor fire door was a pocket type door which had be be manually pulled to close it.</p>	K0044	<p>K0441. The pocket type door has been removed and new fire door has been ordered.2. No other doors were affected.3. Maintenance Director will be inserviced on new audit tool to check fire doors.4. Maintenance Director will do quality improvement audits on all fire doors weekly times four weeks, then monthly thereafter.</p>	04/21/2012

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	<p>Additionally, the fire door did not have latching hardware. Based on observation at 2:40 p.m., the fire door did not close with the fire alarm. Based on interview with the Maintenance Supervisor at 12:12 p.m., this was a block fire wall.</p> <p>3.1-19(b)</p>			

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K0046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lights for 3 of 11 emergency exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect any resident evacuated through the emergency exit door on the Therapy hall and through Primrose's north and northeast exits in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 03/22/12 at 1:00 p.m., exterior light fixtures were observed at the Therapy, Primrose north and Primrose northeast exits. The exit discharge path from these exits continues around the building where it connects with the Memory emergency exit. From the Primrose north exit to the</p>	K0046	K 046 1. The emergency lighting is now along the sidewalk. 2. No other areas were affected. 3. Maintenance Director will be inserviced on new audit tool to check lighting. 4. Maintenance Director will do quality improvements on the emergency lighting weekly times four weeks, then monthly thereafter.	04/21/2012

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	<p>Memory exit is one hundred and fifty feet. Exterior emergency light fixtures were not observed along this sidewalk. Based on interview with the Maintenance Supervisor at the time of observation, the exit discharge path for the one hundred and fifty feet would not have emergency lighting coverage.</p> <p>3.1-19(b)</p>			

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K0048 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan which included the use of all fire extinguishers in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect any number of occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/22/12 at 11:48 a.m., the</p>	K0048	K 048 1. The Disaster Action Plan has been updated to include K class fire extinguisher in the kitchen 2. No other areas were affected 3. Disaster Action Plan will be checked by the administrator to ensure all is updated. 4. Administrator will check Disaster Action Plan monthly to ensure all material is updated	04/21/2012

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	<p>"Disaster Action Plan" did not address the kitchen K class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire and Evacuation Drill Evaluation" with the Maintenance Supervisor on 03/22/12 at 11:20 p.m., the fire drill form for 10/31/11 at 4:45 p.m. and 02/29/12 at 5:15 p.m. indicated the drill was a silent drill where the Maintenance Supervisor "walked thru steps" or "discussed procedures" with the second shift employees. An actual fire drill did not take place. Based on an interview with the Maintenance</p>	K0050	<p>K 050 1. Maintenance Director will do the fire drill correctly and use form provided by surveyor. 2. No other issues were affected. 3. Maintenance Director was inserved on use of new form. 4. Administrator will check to ensure all fire drills are done properly monthly.</p>	04/21/2012			

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	<p>Supervisor at the time of record review, he was not aware fire drill discussion and training could not replace an actual fire drill.</p> <p>3.1-19(b) 3.1-51(c)</p>			

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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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K0052 SS=E	<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</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2, "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect any number of residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare smoke detector records titled "Sensitivity Test and Inspection Report" with the Maintenance</p>	K0052	<p>K 052 I. Safecare has now all 41 smoke detectors have had the smoke detector sensitivity test. 2. No other issues were affected. 3. Safecare will be instructed to ensure all smoke detectors will be checked. 4. Administrator or Maintenance Director will check reports to ensure all smoke detector have been checked before Safe care leaves building.</p>	04/21/2012

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	<p>Supervisor on 03/22/12 at 11:35 a.m., only forty of the forty one smoke detectors in the facility received a smoke detector sensitivity test. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>			

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K0056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the Primrose hall shower room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the Primrose shower room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/22/12 at 1:46 p.m., the Primrose shower room had two sprinkler heads located five feet</p>	K0056	K 056 1. The one sprinkler head has now been removed. 2. No other areas were affected. 3. Maintenance Director will be inserviced on quality improvement audit tool. 4. Maintenance Director will check sprinkler heads throughout building to ensure no others are affected.	04/21/2012			

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	<p>apart. Measurements were provided by the Maintenance Supervisor at the time of observation.</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 ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. 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, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a</p>	K0144	K 144 I. The Maintenance Director will now properly test the generator. 2. No other areas were affected. 3.. Maintenance Director has been inserviced by the generator company on the proper way to test the generator monthly. 4. Administrator will check documentation of generator tests weekly for four weeks, then monthly thereafter.	04/21/2012

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	<p>written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the "Generator Audit" with the Maintenance Supervisor on 03/22/12 at 11:45 a.m., the generator test log showed a monthly load test for the past twelve months but the log did not indicate if the diesel generator was exercised under operating conditions, by maintaining the minimum exhaust gas temperatures or at least thirty percent of the EPS nameplate rating monthly for a minimum of thirty minutes. Based on an interview with the Maintenance Supervisor at the time of record review, the generator was exercised for approximately thirty minutes monthly but when asked about the cool down time, he stated the generator ran for only thirty minutes and did not know</p>						

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	<p>the cool down time period and was not aware the generator was required to run under load for thirty minutes before starting the cool down period.</p> <p>3.1-19(b)</p>			