

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
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K 000 Bldg. 01	<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: 05/07/14</p> <p>Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300</p> <p>At this Life Safety Code survey, Life Care Center of Rochester 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in the resident rooms. The facility has a capacity of 141 and had a census of 81 at the time of this survey.</p>	K 000		

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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K 021 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. The facility had one detached garage used for facility storage which was not sprinklered.</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. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 self closing kitchen doors were provided with a hold open device that would release with the fire alarm and cause the door to automatically close and latch into the door frame. This deficient practice could affect any resident using the dining room and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>			K 021	<p>K021 All dietary staff will received an in-service on door safety on May 22 2015 . Dietary staff is using steam table to serve this will allow the kitchen door to remain shut. Safe care will be installing a mag lock May 31 2015. The new lock will have an automatic release that will allow the door to close automatically when the fire system is triggered.</p>		05/31/2015

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K 025 SS=F Bldg. 01	<p>facility with the Plant Manager on 05/07/15 at 11:09 a.m., the kitchen door to the dining room was equipped with a self closing device and latched in to the frame but was held open by a locking self closing device that did not automatically release with the fire alarm. Based on interview at the time of observation, the Plant Manager acknowledged the device holding the door open did not release with the fire alarm.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC</p>	K 025	KO25 All unsealed penetrations are to be resealed with approved caulking material by June 5 2015 by Walter construction with fire barrier sealant CP25WB+. Ceiling tiles on 300 skilled, 300 rehab, and 300 laundry exit will be re-caulked with approved rating material and completed material by June 5 2015 by Walter Construction. The	06/05/2015

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	<p>Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 practice could affect at least 30 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Plant Manager on 05/07/15 from 1:20 p.m. to 2:35 p.m., the following smoke barrier walls had unsealed penetrations or penetrations sealed with an unapproved material:</p> <p>a) above the ceiling tiles of the 300 skilled smoke barrier all penetrations were sealed with a gray or yellow caulk.</p> <p>b) above the ceiling tiles of the 300 rehab smoke barrier all penetrations were sealed with a gray or yellow caulk.</p> <p>c) above the ceiling tiles of the 300 laundry/exit smoke barrier all penetrations were sealed with a gray or yellow caulk.</p> <p>Based on interview at the time of observation, the Plant Manager did not know if the gray or yellow caulk was an approved material and did not have the</p>		<p>caulking material information will be obtained and kept on file in the maintenance department. All sprinklers were inspected on 5/15/2015 by Safe Care. The excursions on the sprinkler heads in rooms 206,207,203 were refastened on 5/15/2015. The two holes two inches in size in maintenance storage areas were sealed with dry wall on 5/15/2015. In the mechanical room 2 holes measuring 1 inch in size will be sealed by June 11 2015 by Walter construction. In the front mechanical room all the ceiling wall joints will be resealed with appropriate fire safety sealant by June 11 2015 by Walter Construction.</p>	

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	<p>documentation to show the caulk met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 practice can affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Plant Manager on 05/07/15 between 10:00 a.m. and 2:00 p.m., the following unsealed or improperly sealed penetrations were noted :</p> <p>a.) measuring a half of an inch to one fourth of an inch around sprinkler heads</p>				

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K 029 SS=F Bldg. 01	<p>in rooms 206, 207, and 203.</p> <p>b.) in the maintenance storage room there were two holes measuring two inches in size.</p> <p>c.) in the center mechanical room there were two holes measuring one inches in size.</p> <p>d.) in the front mechanical room all penetrations and ceiling wall joints were sealed with a gray or yellow non-fire rated caulk.</p> <p>Based on interview at the time of observation, the Plant Manager acknowledged and provided the measurements of the penetrations. Also, Plant Manager did not know if the gray or yellow caulk was an approved material and did not have the documentation to show the caulk met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <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</p>						

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	<p>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 a smoke resistance in 4 of 12 hazardous areas such a hot water furnace room. This deficient practice could affect all residents of the facility</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Plant Manager on 05/07/15 from 11:30 a.m. to 1:45 p.m., the following was noted:</p> <p>a.) in the 200 hall boiler/furnace closet there was a one inch unsealed penetration around a vent pipe through ceiling.</p> <p>b.) in the 300 hall laundry boiler/furnace room there were five unsealed penetrations measuring one inch to one fourth of a inch around wires, pipes, and conduits through the ceiling.</p> <p>c.) in the central boiler/furnace room between the 200 and 300 halls there were two unsealed penetrations measuring one inch to one fourth of a inch around wires, pipes, and conduits through the ceiling.</p> <p>d.) in the south boiler/furnace room there were seven unsealed penetrations measuring one inch to one fourth of a inch around wires, pipes, and conduits through the ceiling.</p>	K 029	<p>K029</p> <p>The 200 hall one inch unsealed penetration around the ceiling vent pipe in the boiler furnace closet will be sealed with appropriate fire safety sealant by June 11 2015 By Walter Construction.</p> <p>In the 300 hall laundry boiler room the five unsealed ceiling penetrations in the laundry boiler/furnace room will be sealed with appropriate fire safety sealant June 11 2015 by Walter Construction.</p> <p>The one inch to four inch penetrations in the central boiler furnace room pipes between 200 and 300 halls will be sealed with appropriate fire safety sealant by June 11 2015 Walter Construction.</p> <p>In the south boiler furnace room 7 unsealed penetrations measuring 1inch + around wires pipes and conduits will be sealed with appropriate fire safety sealant by June 11 2015 by Walter Construction.</p> <p>The south door entering the laundry room was lubricated with WD40. The door now latches appropriately.</p>	06/11/2015

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	<p>Based on interview, the measurements were provided by the Plant Manager at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the 2 of 12 corridor doors to hazardous areas were provided with self closers and would latch into the frame. This deficient practice could affect 31 residents on the 300 Hall and 24 residents on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 05/07/15 between 11:00 am and 12:38 p.m., the following was noted:</p> <p>a) the south door entering the laundry room was equipped with a self closing device but failed to latch into the door frame.</p> <p>b) the door entering the soiled utility room on the 200 hall was equipped with a self closing device but failed to latch into the door frame due to the door catching on the floor.</p> <p>Based on interview, this was acknowledged by the Plant Manager the time of observation.</p> <p>3.1-19(b)</p>		<p>The door entering the soiled utility room was slightly readjusted into the frame and lubricated with WD40. The door no longer drags on the floor and is self-closing.</p>	

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K 046 SS=F Bldg. 01	<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 ensure 2 of 2 emergency light fixtures of at least 30 seconds duration was tested monthly and 1½ hour duration tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for at least 1½ hour duration. 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 could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation during tour of the facility and records review with the Plant Manager on 5/07/15 at 10:30 a.m.,</p>	K 046	<p>Battery powered emergency lightening has been added to the preventive maintenance program. The emergency lightening will be tested 1x a month for 30minutes and 1x a year for 1 ½ hrs. The information is logged into the computerized tells system and a log is kept in the maintenance department for inspection.</p>	05/26/2015

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K 062 SS=D Bldg. 01	<p>a battery operated emergency light log was not available for the emergency light for the generator and in the sprinkler riser room showing that a 30 seconds duration was tested monthly and 1½ hour duration tested annually. Based on an interview at the time of observation, the Plant manager stated he was testing the emergency light but was not documenting his tests.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 1 automatic sprinklers in the laundry boiler room which was corroded. 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 was not in a patient treatment area but could 2 staff in working in the</p>	K 062	<p>K062</p> <p>The automatic sprinkler in the boiler laundry room will be replaced by May 31 2015. Sprinklers were placed on a schedule to be inspected every quarter by a professional sprinkler inspection company and monthly by the plant manager.</p>	05/31/2015			

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K 147 SS=D Bldg. 01	<p>boiler room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Supervisor on 05/07/15 at 11:25 a.m., one automatic sprinkler in the boiler room located in the laundry room was corroded with a green substance. Based on interview at the time of the observation, the Plant Manager acknowledged the sprinkler head was corroded.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 receptacles near a wet location 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 subjected 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</p>	K 147	<p>K147</p> <p>The receptacle in the central medicine room was replaced to an approved GFCI protected receptacle May 26, 2015.</p>	05/26/2015

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	<p>the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff with access to the central medicine room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Plant Manager on 05/07/15 at 12:38 p.m., there was an electrical receptacle not GFCI protected on the wall less than three feet from a sink in the central medicine room. Based on interview and testing, the plant manager acknowledged the receptacle was not provided with GFCI protection and when tested with a GFCI testing device power was not interrupted at the receptacle.</p> <p>3.1-19(b)</p>				