

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2015
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NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947
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K 000 Bldg. 03	<p>A Life Safety Code Survey for the addition of 16 Title 19 beds in rooms 33, 34, 35, 36, 37, 38, and 42 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/30/15</p> <p>Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist; W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Camelot 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 18, New 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</p>	K 000	<p>Submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of correction as our credible allegation of compliance.</p>	

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 014 SS=E Bldg. 03	<p>alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 91 and had a census of 57 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and 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. Lower portions of corridor walls can be Class C. 18.3.3.1, 18.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of an interior finish material installed within the exit access corridor between the ventilator unit and the original healthcare portion of the facility. This deficient practice could affect any resident in the ventilator unit as well as staff and visitors.</p>	K 014	<p>1. No residents were affected. 2. All carpet on the walls in the entire facility have been treated with flame shield multi-purpose fire retardant. 3. The Housekeeping supervisor was educated on the use of the flame shield fire retardant. 4. A schedule has been created to ensure carpeted walls are treated and cleaned and retreated with the flame shield fire retardant.</p>	04/02/2015

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K 062 SS=B Bldg. 03	<p>Findings include:</p> <p>Based on observation on 03/30/15 from 10:00 a.m. to 12:00 p.m. with the Administrator and Maintenance Supervisor, there was carpeting installed on the lower third of the walls in the breeze way corridor. Interview with the Maintenance Supervisor and Administrator during the time of observation revealed no documentation was available to demonstrate that the carpeting provides a flame spread rating of Class C or had been treated.</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 2 of 2 sprinklers in room 35 which had paint on them. 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</p>	K 062	<p>Supervisor will report the status of the scheduled cleaning and retreating of the carpet quarterly to the quality assurance committee. Monitoring will be ongoing for continued compliance</p> <p>1. No residents were affected. 2. Brenneco provided service and changed the two affected sprinkler heads. 3. All other sprinkler heads were inspected to ensure they are maintained in accordance with NFPA. 4. Maintenance check list has been updated to include monthly inspections of the cleanliness of sprinkler heads. Maintenance supervisor will report the results of the sprinkler head inspection to</p>	04/01/2015

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K 067 SS=E Bldg. 03	<p>painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect two residents, staff and visitors in the vicinity of resident room 35.</p> <p>Findings include:</p> <p>Based on observation on 03/30/15 from 10:00 a.m. to 12:00 p.m. with the Administrator and Maintenance Supervisor, the two sprinklers in room 35 had paint on the bulb and deflector and were in need of replacement. Based on interview at the time of observation, the Administrator and Maintenance Supervisor acknowledged the ceiling had been recently painted and the aforementioned automatic sprinklers had paint on them as well.</p> <p>3.1-19(b)</p> <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 and interview, the facility failed to ensure 42 of 42 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A.</p>	K 067	<p>the quality assurance committee monthly for 3 months and quarterly thereafter. Monitoring will be ongoing for continued compliance.</p> <p>1. No residents were affected. 2. Maintenance Director was educated on the requirement for damper inspections. 3. Maintenance supervisor inspected and provided necessary maintenance</p>	03/31/2015	

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	<p>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 could affect all residents, staff and visitors on the ventilator unit.</p> <p>Findings include:</p> <p>Based on observation on 03/30/15 from 10:00 a.m. to 12:00 p.m. with the Administrator and Maintenance Supervisor, forty two fire dampers with fusible links were observed in the heating, ventilation and air conditioning (HVAC) supply and vent ducts in the ceilings of the resident rooms, offices and the main entrance. Interview with the Maintenance Supervisor and Administrator during the time of observation revealed no documentation was available to demonstrate that the forty two fire dampers had ever been inspected and provided with the necessary maintenance since the building</p>		to all fire/smoke dampers. 4. All dampers were added to the preventative maintenance check list to be completed at least every 4 years. Monitoring will be ongoing for continued compliance		

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K 211 SS=E Bldg. 03	<p>was originally built in the late 1980's.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure alcohol based hand rub dispensers in 3 of 8 resident rooms were not installed over or adjacent to an ignition source. This deficient practice could affect at least 6 of 18 residents, staff and visitors on the ventilator unit.</p> <p>Findings include:</p> <p>Based on observation on 03/30/15 from 10:00 a.m. to 12:00 p.m. with the Administrator and Maintenance</p>	K 211	<p>1. No residents were affected. 2. All affected alcohol based hand rub dispensers were moved to ensure dispensers were not installed over or adjacent to an ignition source. 3. All other alcohol based hand rub dispensers were checked to ensure dispensers were not located over or adjacent to and ignition source. 4. Housekeeping supervisor has added alcohol based hand rub dispensers to her room check list to ensure dispensers are not located or installed over or adjacent to an ignition source. Housekeeping</p>	04/02/2015

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	Supervisor, there were alcohol based hand rub dispensers mounted on the wall inside the resident room above the light switch that were not more than six inches away in rooms 33, 34 and 37. The dispensers contained 67 % ethyl alcohol. Based on an interview with the Administrator and Maintenance Supervisor, it was acknowledged the alcohol based hand sanitizer dispensers were mounted either mounted directly above an ignition source or were adjacent by six inches or less. 3.1-19(b)		supervisor will report the results of the rooms check list to the quality assurance committee monthly for 3 months and quarterly thereafter. Monitoring will be ongoing for continued compliance		