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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155207 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 01/13/2014 |
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| NAME OF PROVIDER OR SUPPLIER NEW HAVEN CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774 |
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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: 01/13/14</p> <p>Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, New Haven 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 V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated</p> | K010000 | <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, New Haven Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies."</p> | |
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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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| K010014 SS=E | <p>smoke detectors in the resident rooms. The facility has a capacity of 120 and had a census of 89 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a detached building housing the emergency generator and used for storage of maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/21/14.</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. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior</p> | K010014 | 1, 2, & 3. Wall mounted carpeting treated with fire retardant spray on 12/19/11. Documentation provided that | 01/14/2014 | | | |

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| K010038 SS=E | <p>finish materials installed within exit access for 5 of 6 corridors throughout the facility. This deficient practice could affect 70 of 89 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 01/13/14 during the tour from 11:00 a.m. to 3:40 p.m., there was carpet installed on the bottom one third of the corridor walls throughout the facility with the exception of the 2008 remodeled area which includes the 200 hall. Interview with the Director of Maintenance at 12:30 p.m., indicated documentation was not available to demonstrate the carpet provides a flame spread rating of Class A or Class B.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure 2 of 2 exit doors in the main dining room were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a</p> | K010038 | <p>carpeting provides flame spread protection on 1/14/14. 4. Continued monitoring of wall mounted carpeting for flame spread protection by Administrator and Maintenance Director daily and during monthly Performance Improvement meeting.</p> <p>1. Main Dining room exit doors provided with signage stating "Push until alarm sounds door can be opened in 15 seconds." 2. Maintenance Director reviewed all doors secured by electromagnetic locks to confirm proper signage is displayed. 3. Facility staff re-educated by Maintenance Director and</p> | 01/14/2014 | | | |

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| K010062 SS=E | <p>readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect residents in the main dining room which seats 40 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 01/13/14 at 12:53 p.m., the main dining room exit doors were equipped with electromagnetic locks that released after 15 seconds after initiation of the alarm cycle. Neither door displayed the proper signage regarding the delayed egress. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-15(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 ensure spare sprinkler heads were provided for 5 of 12 exits.</p> | K010062 | <p>designees 1/14/14 on electromagnetic locking doors and signage regarding delayed egress. 4. Continued monitoring of electromagnetic locks and signage by Maintenance Director daily and monthly during Performance Improvement meeting.</p> <p>1, 2, & 3. Maintenance Director obtained additional sidewall sprinkler heads for the spare sprinkler box. 4. Continued</p> | 02/12/2014 | | | |

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| | <p>NFPA 25, 1998 Edition, Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 01/13/14 from 1:00 p.m. to 1:52 p.m., sidewall sprinkler heads were installed at the overhangs on the 400 hall, north lounge, 100 hall and both emergency exits on the 200 hall. Based on an interview with the Director of Maintenance at 1:00 p.m., he agreed there were no sidewall sprinkler heads in the spare sprinkler box.</p> <p>3.1-19(b)</p> | | <p>monitoring for spare sidewall sprinkler heads daily by Maintenance Director or designee and during monthly Performance Improvement meeting.</p> | | |

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| K010066 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 and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. This deficient practice could affect residents in the main dining room which seats 40 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 01/13/14 at 12:53 p.m., there were at least thirty cigarette butts in a large metal can without a self closing lid at the patio off</p> | K010066 | <p>1. Cigarette butts and metal can removed from non-designated smoking area by Maintenance Director. 2. Maintenance Director reviewed facility grounds to confirm that smoking materials and secured receptacles are being utilized in designed smoking areas. 3. Facility staff re-educated by Maintenance Director and designees 1/14/14 on safe smoking practices and locations. 4. Continued monitoring of smoking practices and locations by Maintenance Director or designee daily and monthly during Performance</p> | 01/14/2014 | | | |

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| K010067 SS=F | <p>of the main dining room. Based on an interview with the Director of Maintenance at the time of observation, the patio is not a designated smoking area.</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. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 34 of 34 dampers in the ceiling vents 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 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 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 all residents, staff and visitors.</p> | K010067 | <p>Improvement meeting.</p> <p>1 & 2. All facility dampers inspected and tested by certified contractor. Fusible links replaced with new fuse. 3) Maintenance Director and designees will schedule damper inspections, testing and fuse link replacement in accordance with four year annual inspection requirements. 4. Continued monitoring of dampers by Maintenance Director or designee daily and monthly during Performance Improvement meeting.</p> | 02/12/2014 | |

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| K010070 SS=C | <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 01/13/14 at 2:42 p.m., there was an exhaust vent penetrating the smoke barrier wall above the drop down ceiling at the 400 hall smoke barrier doors. The Director of Maintenance stated the exhaust vent was connected with the exhaust fan in the resident room bathrooms. He stated each bathroom exhaust vent had a ceiling damper with a fusible link. He stated these dampers have not been inspected and tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 policies regarding the use of portable space heaters in the facility was in accordance with NFPA 101, Section</p> | K010070 | 1, 2, & 3. Administrator & Maintenance Director amended policy as it relates to space heaters to reflect that space heaters are not allowed in resident care areas. Information added to space heater policy | 01/14/2014 | | | |

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| | <p>19.7.8. This deficient practice could affect any number of residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance on 01/13/14 at 12:10 p.m., under the "Policy for Life Safety" it states "no portable heaters are allowed in resident rooms. It is strongly encouraged that heaters not be used in office spaces." The policy does not state space heaters are prohibited in resident care areas. Additionally, the policy does not state the heating elements shall not exceed 212 degrees F. This was acknowledged by the Director of Maintenance at the time of record review.</p> <p>3.1-19(b)</p> | | <p>reflects that heating elements shall not exceed 212 degrees Fahrenheit. 4) Continued monitoring of space heater policy by Administrator and Maintenance Director during monthly Performance Improvement meeting.</p> | | |

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| K010075 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 2 of 60 resident rooms. This deficient practice could affect 2 of 89 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 01/13/14 from 1:50 p.m. to 2:05 p.m., one 28 gallon container of biohazardous soiled linen and one 28 gallon container of biohazardous trash were adjacent one another in resident rooms 201 and 208. Based on an interview with the Director of Maintenance at time of observation, he confirmed the containers had a capacity of 28 gallons and they were used for biohazardous waste and linen.</p> | K010075 | <p>1. Biohazardous containers in rooms 201 & 208 removed by Maintenance Director and replaced with containers of appropriate size as per square footage of rooms. 2) Maintenance Director reviewed all resident rooms to confirm biohazardous containers of appropriate size were utilized in relation to square footage of room. 3) Facility staff re-educated by Maintenance Director and designees 1/14/14 on biohazardous container size and proper utilization as per square footage of resident rooms. 4) Continued monitoring of biohazardous containers by Administrator and Maintenance Director daily and during monthly Performance Improvement meeting.</p> | 01/14/2014 | | | |

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| K010076 SS=E | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to store 1 of 4 liquid oxygen containers in a room constructed with a one hour separation. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 01/13/14 at 2:12 p.m., a stationary liquid oxygen unit was observed near the entrance door to the service hall. Based on an interview with the Director of Maintenance at the time of observation, he was unable to confirm how long the liquid oxygen unit had been stored in the corridor.</p> | K010076 | <p>1. Oxygen tank in service hallway removed by Maintenance Director and placed in designated oxygen room. 2. Maintenance Director and designees reviewed facility to confirm that all oxygen tanks were stored as appropriate. 3. Facility staff re-educated by Maintenance Director and designees 1/14/14 on oxygen tank utilization and storage location. 4) Continued monitoring of oxygen tank utilization and storage by Maintenance Director and designees daily and during monthly Performance Improvement meeting.</p> | 01/14/2014 | | | |

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| K010130 SS=C | <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 60 of 60 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 01/13/14 during the tour from 11:00 a.m. to 3:40 p.m., battery operated smoke detectors were installed in all resident rooms. Based on record review with the Director of Maintenance on 01/13/14 at 11:45 a.m., the smoke detectors were tested quarterly. The Director of Maintenance stated he tests the smoke detector quarterly because that's what the TEL's program requires.</p> | K010130 | 1, 2, & 3. Maintenance Director and designees completed facility wide testing of smoke detectors to confirm functionality. Smoke detectors will be tested monthly and as needed. 4) Continued testing of smoke detectors by Maintenance Director and designees monthly and as needed. Results reviewed during monthly Performance Improvement meeting. | 01/16/2014 |

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