

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
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K 0000 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: 03/08/16</p> <p>Facility Number: 012993 Provider Number: 155806 AIM Number: 201208210</p> <p>At this Life Safety Code survey, Wellbrooke of Wabash 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>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 and in spaces open to the corridors with hard wired smoke detectors in all the resident sleeping rooms. The facility has a capacity of 70 and had a census of 42 at the time of this survey.</p>	K 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. Wellbrooke of Wabash desires this Plan of Correction to be considered the facility's allegation of compliance effective on March 22, 2016. Wellbrooke of Wabash respectfully requests a desk review with paper compliance be considered in establishing that the provider is in substantial compliance. We appreciate your consideration of this request.</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 0018 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 5 of 66 resident room corridor doors in the facility closed and latched into the door frame. This deficient practice affects all residents in both of the sleeping area hallways.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services on 03/08/16 between 11:00 a.m. and 12:47 p.m., the corridor door to resident rooms 210, 233, 103, 105, 109, and 119 failed to latch into the door frame. Based on interview, this was acknowledged by the Director of Plant Services at the time of observations.</p>	K 0018	<p>K 018 – It is the policy of this facility to ensure that any door protecting corridor openings shall be constructed to resist the passage of smoke. 1. What corrective action will be accomplished for residents affected? All doors on both 100 and 200 halls have been reinspected for closure and latching. All doors are back in full functional status including Rooms 210, 233, 103, 105, 109, and 119.2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected. The facility was toured to verify that all doors are functional and latching</p>	03/15/2016

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K 0025 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke</p>	K 0025	<p>properly.3. What measures will be put in place to ensure this practice does not recur? The Executive Director and/or Maintenance Director will tour the facility monthly to ensure that the doors are latching properly.4. How will the corrective action be monitored to ensure the deficient practices does not recur and what QA will be put into place? Findings from the Executive Director and/or Maintenance Director's tour will be forwarded to the QA&A committee for further review at the monthly meeting. After 180 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee.5. Date of compliance: March 15, 2016</p> <p>K 025 – It is the policy of this facility to ensure smoke barriers are constructed to provide at least a one-hour fire resistance rating.</p> <p>1. What corrective action will be accomplished for residents affected? The fire caulking was replaced in the areas that could have caused penetration. All areas</p>	03/09/2016	

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K 0027 SS=F Bldg. 01	<p>barriers to be constructed in accordance with LSC Section 8-3. 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 could affect up to 35 residents in 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Services on 03/08/16 at 1:22 p.m., in the smoke barrier wall above the ceiling tiles by room 214 there was two unsealed fourth of an inch penetrations around a conduit. Based on interview at the time of observation, the Director of Plant Services acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non-</p>		<p>now have at least a one-hour fire resistance rating.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected. The facility was toured to verify that all areas that could cause penetration have a one-hour fire resistance rating.</p> <p>3. What measures will be put in place to ensure this practice does not recur? The Executive Director and/or Maintenance Director will tour the facility monthly to ensure that any penetrations have fire caulking to provide a one-hour fire resistance rating.</p> <p>4. How will the corrective action be monitored to ensure the deficient practices does not recur and what QA will be put into place? Findings from the Executive Director and/or Maintenance Director's tour will be forwarded to the QA&A committee for further review at the monthly meeting. After 180 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee.</p> <p>5. Date of compliance: March 9, 2016</p>		

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	<p>rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 sets of smoke barrier doors were equipped with rabbets, bevels, or astragals at the meeting edges. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Director of Plant Services on 03/08/16 between 10:00 a.m. and 1:00 p.m., all smoke barrier door sets in the facility were not equipped with rabbets, bevels, or astragals at the meeting edges of the doors. Based on interview during time of observation, the Director of Plant Services acknowledged that none of the smoke barriers doors were equipped with rabbets, bevels, or astragals at the meeting edges of the doors.</p> <p>3.1-19(b)</p>	K 0027	<p>K 027 – It is the policy of this facility for doors to be self closing and rabbets, bevels, or astragals are present at the meeting edges.1. What corrective action will be accomplished for residents affected? Astragals were purchased and installed in 6 of 6 sets of smoke barrier doors.2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents had the potential to be affected. The astragals have been installed in all resident areas.3. What measures will be put in place to ensure this practice does not recur? The Executive Director and/or Maintenance Director will tour the facility monthly to ensure that the astragals are in place to the self closing doors.4. How will the corrective action be monitored to ensure the deficient practices does not recur and what QA will be put into place? Findings from the Executive Director and/or Maintenance Director's tour will be forwarded to the QA&A committee for further review at</p>	03/22/2016

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			the monthly meeting. After 180 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee. Date of Compliance: March 22, 2016		