

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155073	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2016
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NAME OF PROVIDER OR SUPPLIER  PILGRIM MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PLYMOUTH, IN 46563
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K 0000  Bldg. 02	<p>An Initial Life Safety Code Certification 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: 06/21/16</p> <p>Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260</p> <p>At this Life Safety Code Preoccupancy survey, Pilgrim Manor addition was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The</p>	K 0000	Please accept this POC as our allegation of compliance. All deficiencies were corrected on 6-22-16. We are requesting you to review and grant a paper compliance. If you have any questions, please do not hesitate to contact us	
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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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K 0025 SS=D Bldg. 02	<p>facility has a capacity of 78 and had a census of 0 in the two additions.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 06/22/16 - DA</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 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. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 06/21/16 at 10:00 a.m., three separate one and a half inch unsealed ceiling penetrations inside conduit were</p>	K 0025	<p>1 No residents were affected by that deficient practice 2 No residents are located in the sections of the building surveyed; therefore no residents had the potential to be affected The conduit penetrations have been sealed with fire rated putty material (See Exhibit 1, before picture and Exhibit 2 after corrected picture - this shows 2 penetrations) (Exhibit 3 before picture and Exhibit 4 after picture shows the other 2 penetrations fixed) 3 When the IT company comes and works on any wiring, Maintenance will inspect the area the wiring occurred to insure no wall penetrations have been made (See Exhibit 5) 4</p>	06/22/2016			

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K 0064 SS=D Bldg. 02	<p>discovered in the Mechanical IT room. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Mechanical IT room fire extinguisher was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 06/21/16 at 10:03 a.m., the Mechanical IT room fire extinguisher</p>	K 0064	<p>Maintenance will inspect the Mechanical IT room monthly to ensure there are no wall penetrations (See Exhibit 6) Maintenance will present the inspection results at each monthly QA meeting (See Exhibit 7)</p> <p>1 No residents were affected by that deficient practice 2 No residents are located in the sections of the building surveyed; therefore no residents had the potential to be affected The fire extinguisher was lowered to 59 1/2" (See Exhibit 8 - picture of complete fire extinguisher and Exhibit 9 - picture of zoomed in fire extinguisher with measurement) 3 When Maintenance checks the fire extinguishers monthly, they will ensure that all fire extinguisher handles are lower than 60" (See Exhibit 17) 4 Maintenance will present any issues or concerns at each monthly QA meeting (See Exhibit 7)</p>	06/21/2016	

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K 0130 SS=E Bldg. 02	<p>measured 61.5 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS Miscellaneous</p> <p>List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. THER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of</p>	K 0130	<p>1 No residents were affected by that deficient practice 2 No residents are located in the sections of the building surveyed; therefore, no residents had the potential to be affected. All penetrations have been sealed with fire rated putty material or drywall/spackling compound (See Exhibit 10 before picture and Exhibit 11 after corrected picture - for 2 - 3" penetrations) (Exhibit 12 is after corrected picture of 2 - 3/4" penetrations) (Exhibit 13 is before picture and Exhibit 14 is after picture of the 2" penetrations around conduit), (Exhibit 15 is the before picture and Exhibit 16 is the after picture of 1" unsealed penetration) 3</p>	06/22/2016

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	<p>the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and up to 28 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and Maintenance Director on 06/21/16 at 10:33 a.m. then again at 10:39 a.m., two separate three inch unsealed penetrations inside conduit in the C Wing fire barrier. Additionally, two separate three quarter inch unsealed penetrations. Then again, two inch penetrations around conduit and a one inch unsealed penetration in the B Wing</p>		<p>When the IT company comes and works on any wiring, Maintenance will inspect the area the wiring occurred to insure no smoke/fire wall penetrations have been made (See Exhibit 5) 4 Maintenance will inspect the Mechanical IT room the smoke/fire barrier walls monthly to ensure there are no wall penetrations (See Exhibit 6). (See Exhibit Maintenance will present the inspection results at each monthly QA meeting (See Exhibit 7)</p>	

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	fire barrier. Based on interview at the time of each observation, the Administrator and Maintenance Director acknowledged each aforementioned condition and provided the measurements.  3.1-19(b)						