

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2016
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NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
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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: 05/23/16</p> <p>Facility Number: 011906 Provider Number: 155772 AIM Number: 200912380</p> <p>At this Life Safety Code survey, Cobblestone Crossing Health Campus 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 alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms. The facility has a capacity of 60 and had a census of 50 at the time of this survey.</p>	K 0000		

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 0011 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/26/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barrier to a nonconforming building was protected by a two hour fire wall. This deficient practice could affect 25 or more residents, as well as staff and visitors while in the main Dining Room.</p> <p>Findings include:</p> <p>Based on observation on 05/23/16 at 11:45 a.m. during a tour of the facility with the Director of Plant Operations, the fire wall in the attic between the kitchen and main dining room had four</p>	K 0011	<p>There were no residents that suffered ill effects from this finding</p> <p>All residents have the potential to be affected by the alleged deficient practice and through corrective action the campus will assure all areas that penetrate the fire barrier are filled utilizing materials that have at least a two hour fire resistance construction rating.</p> <p>Systemic changes are the campus and it's contractors will only utilize materials that have at least a two hour fire resistance construction rating to fill new areas that penetrate through a fire barrier.</p>	06/17/2016

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K 0038 SS=E Bldg. 01	<p>penetrations through the wall which were not properly fire stopped. A four inch sprinkler main, a two inch drain pipe, a wire bundle with four wires and a half inch conduit with a wire running through it penetrated the wall with expandable foam sealing the openings. Based on interview , The Director of Plant Operations acknowledged the penetrations and was unable to provide documentation for the expandable foam demonstrating the product was approved for use as a though penetration fire stop product for commercial use.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure a way of exit was maintained for 1 of 8 exits. LSC 7.1.1 states means of egress for both new and existing buildings shall comply with this chapter. LSC 7.7.1 requires exits to terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size, to provide all occupants with a safe access to a public way. LSC 7.1.10.1 requires means of egress to be</p>	K 0038	<p>Plant Operations Director has been in serviced on only utilizing materials that have at least a two hour fire resistance construction rating to fill new areas that penetrate through a fire barrier.</p> <p>Plant Operations Director or Designee will audit all repairs to fire barriers for verification of correct materials used by all contractors and report findings to QA monthly for 12 months.</p> <p>There were not any residents affected by the alleged deficit.</p> <p>All resident have the potential to be affected and through corrective action the campus will ensure there are exits that are readily accessible at all time in accordance with 7.1.18.2.1, 19.2.1.</p> <p>Systemic changes are the campus will contract an outside agent to install a new sidewalk to provide a means of emergency exit that is accessible at all times and provides access to a public way.</p>	06/17/2016

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	<p>continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>This deficient practice could affect 21 residents, as well as staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/23/16 at 11:15 a.m. during a tour of the facility with the Director of Plant Operations, there was no sidewalk outside the 200 Hall exit door. The entire area was under construction due to a new building being built outside this exit. There was a partial rock and dirt walk way to the right, but, it stopped at a grassy area and did not lead to a public way. It was also uneven and soft. Based on interview at the time of observation, the Director of Plant Operations acknowledged the 200 Hall exit did not lead to a public way.</p> <p>3.1-19(b)</p>		<p>Plant Operations Director or designee will monitor the completion of new sidewalk and emergency exit and report to the QA Committee X 6 months.</p>		