

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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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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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: 02/19/15</p> <p>Facility Number: 012993 Provider Number: 155806 AIM Number: 201208210</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist.</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</p>	K010000	<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 3, 2015. 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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K010021 SS=E	<p>and had a census of 45 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>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/25/15.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure that 1 of 1 doors from the dining room to the kitchen, a</p>	K010021	K 021 – It is the policy of this facility to ensure that any door in a hazardous area enclosure is	03/03/2015			

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	<p>hazardous area, would self close and latch into the door frame. This deficient practice could affect any of the facility's residents that use the dining room.</p> <p>Findings include: Based on observation during the tour of the facility with the Director of Plant Services on 2/19/15 at 12:36 p.m., the door separating the kitchen from the skilled health center's dining room did have a self closing device, but was held open by a non-approved latching device on the bottom of the door preventing the door from automatically closing. The device is not connected to the fire system and will not release the door upon activation of the fire alarm. Based on interview at the time of observation, the Director of Plant Services confirmed that the door was held open by a device that would not release with the fire alarm.</p>		<p>held open only by devices arranged to automatically close upon activation of the manual fire alarm system. 1. What corrective action will be accomplished for residents affected? The door leading to the kitchen (hazardous area) area is equipped with a self closing device. The mechanical hold open hardware was removed from the door and cabinet allowing the door closer to operate freely to close and latch the door leading to the hazardous area. 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 leading to a hazardous area have the correct closure equipment. 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 leading to hazardous areas are closing 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</p>		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wires, pipes and/or conduits through 2 of 4 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke 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</p>	K010025	<p>days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee. Date of compliance: March 3, 2015</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 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</p>	03/03/2015			

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	<p>smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 19 residents in the 100 hall.</p> <p>Findings include: Based on observations during the tour of the facility with the Director of Plant Services on 02/19/15 from 1:21 p.m. to 1:50 p.m., the following areas had unsealed penetrations through the smoke barrier walls:</p> <p>a) The smoke barrier wall located in the 100 hall by room 133 contained an open two inch PVC pipe with data cables running through it.</p> <p>b) The smoke barrier wall located in the 100 hall by room 120 had a one and a fourth inch gap around a sprinkler line.</p> <p>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>2. 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</p>		<p>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 3, 2015</p>				

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K010029 SS=E	<p>continuous from an outside wall to an outside wall. This deficient practice could affect 26 residents in the 200 hall.</p> <p>Findings include: Based on observations during the tour of the facility with the Director of Plant Services on 02/19/15 at 11:39 a.m., in the closet of room 232 there was an unsealed one fourth on an inch ceiling penetration around a sprinkler head. 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 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors and have a proper kitchen hood suppression system. This deficient practice could affect any staff, visitor,</p>	K010029	<p>K 029 – It is the policy of this facility to only use fryers in accordance with Life Safety Code Standard 7.2.1.8 and 18.3.2.1</p> <p>1. What corrective action will be accomplished for residents affected? As stated the mobile deep</p>	02/19/2015

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	<p>and resident using the bistro.</p> <p>Findings include: Based on observation during a tour of the facility with the Director of Plant Services on 02/19/15 at 12:55 p.m., onion rings were being deep fried in a mobile deep fryer located in the lobby bistro which is open to the corridor. There was no door separating the cooking area from the corridor. The deep fryer required the use of hot oil and was sitting on a counter with no hood suppression system. There were cardboard boxes next to the fryer on the same counter top, and directly above the fryer there was a shelf containing cardboard boxes. Also, there was visible oil splatter on the cardboard boxes and small pools of oil were on the counter top. Based on interview at the time of observation, the Director of Plant Services acknowledged that the fryer was being used in the bistro, immediately unplugged the fryer, and told staff not to use the fryer.</p> <p>3.1-19(b)</p>		<p>fryer was immediately unplugged and staff was instructed to remove the item from the premises.</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 had the potential to be affected. The facility was toured to verify that all mobile frying devices were removed from the premises. Dietary staff was instructed to no longer use mobile frying devices for any reason.</p> <p>3. What measures will be put in place to ensure this practice does not recur? The Director of Food Service and/or Maintenance Director will tour the facility monthly to ensure that no mobile frying devices are being used. Staff will be instructed that no mobile frying devices can be used within the facility.</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 Director of Food Service 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</p>		

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K010062 SS=E	<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 clean and maintain 1 of 5 sprinklers in the southeast side of the attic above the 200 hall. 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. This deficient practice could affect 19 residents in the 200 hall.</p> <p>Findings include: Based on observation during a tour of the facility with the Director of Plant Services on 02/19/15 at 1:00 p.m., there was an automatic sprinkler located in southeast side of the attic by the attic access panel above room 209 completely covered with insulation making the</p>	K010062	<p>committee.</p> <p>5. Date of Compliance: February 19, 2015</p> <p>K – 062 - It is the policy of this facility that all sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>1. What corrective action will be accomplished for residents affected? Koorsen Fire & Security was called out to clean the sprinklers in the attic area. Koorsen cleaned all sprinklers that had insulation on them.</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. Koorsen Fire & Security inspected 13 attic accesses. All sprinklers that were found with insulation were cleaned with compressed air.</p> <p>3. What measures will be put in</p>	02/25/2015			

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K010069 SS=E	<p>sprinkler head unrecognizable. Based on interview at the time of observation, the Director of Plant Services confirmed that it was a sprinkler head and that it is completely covered with insulation. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors and have a proper kitchen hood suppression system. LSC section 9.2.3 requires commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking</p>	K010069	<p>place to ensure this practice does not recur? The Maintenance Director and/or designee will monitor the sprinklers for any debris monthly during preventative maintenance rounds.</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 Maintenance Director and/or designee'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. Date of Compliance: February 25, 2015</p> <p>K - 069 - It is the policy of this facility that cooking facilities are protected in accordance with 9.2.3.</p> <p>1. What corrective action will be accomplished for residents affected? As stated the mobile deep fryer was immediately unplugged and staff was instructed to remove the item from the premises.</p> <p>2. How will the facility identify</p>	02/19/2015			

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	<p>Operations. This deficient practice could affect any staff, visitor, and resident using the bistro.</p> <p>Findings include: Based on observation during a tour of the facility with the Director of Plant Services on 02/19/15 at 12:55 p.m., onion rings were being deep fried in a mobile deep fryer located in the lobby bistro which is open to the corridor. There was no door separating the cooking area from the corridor. The deep fryer required the use of hot oil and was sitting on a counter with no hood suppression system. There were cardboard boxes next to the fryer on the same counter top, and directly above the fryer there was a shelf containing cardboard boxes. Also, there was visible oil splatter on the cardboard boxes and small pools of oil were on the counter top. Based on interview at the time of observation, the Director of Plant Services acknowledged that the fryer was being used in the bistro, immediately unplugged the fryer, and told staff not to use the fryer.</p> <p>3.1-19(b)</p>		<p>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 facility was toured to verify that all mobile frying devices were removed from the premises. Dietary staff was instructed to no longer use mobile frying devices for any reason.</p> <p>3. What measures will be put in place to ensure this practice does not recur? The Director of Food Service and/or Maintenance Director will tour the facility monthly to ensure that no mobile frying devices are being used. Staff will be instructed that no mobile frying devices can be used within the facility.</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 Director of Food Service 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>Date of Compliance: February 19, 2015</p>		

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, the facility failed to ensure penetrations of 1 of 1 fire barrier walls were protected by an approved device that is designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be designed, constructed, 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. The space between the penetrating item and the fire barrier shall meet one 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 designed for the specific purpose.</p> <p>This deficient practice could affect the all residents of the facility.</p> <p>Findings include:</p>	K010130	<p>K 130 – It is the policy of this facility to ensure penetrations of fire barrier walls are protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier.</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 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</p>	03/03/2015			

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	Based on an observation during the tour of the facility with the Director of Plant Services., the fire wall separating the skilled nursing facility from the assisted living center had six unsealed penetrations ranging in size from one quarter of an inch to one inch around wires, piping and conduits. Based on interview at the time of observation, the Director of Plant Services acknowledged and provided the measurements of the penetrations. 3.1-19(b)		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 3, 2015		