

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2015
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NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN 46580
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/10/15</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>At this Life Safety Code survey, Mason Health Care 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 300 halls and the center hall were surveyed with Chapter 19, Existing Health Care Occupancies.</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 hard wired smoke detectors in the resident rooms. The facility has a</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 0029 SS=E Bldg. 01	<p>capacity of 115 and had a census of 85 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including the storage of activity supplies, maintenance supplies and housekeeping supplies which were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Bio-Hazard rooms, a hazardous area, was smoke resistive. This deficient practice was not in a patient treatment area but could affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0029	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests a	08/28/2015

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K 0072 SS=E Bldg. 01	<p>facility with the Maintenance Director on 08/10/15 Between at 11:25 a.m., in the Bio-Hazard room on the service hall, there was a one fourth of an inch unsealed penetration around a sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurement of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation, review and interview, the facility failed to ensure the means of egress for 1 of 9 exits was continuously maintained free of all obstructions or impediments to full instant use. This deficient practice could affect 25 occupants evacuating through</p>	K 0072	<p>paper review. No residents had the potential to be affected as the bio-hazard room is located in a secured and locked area, in a corridor leading to the outside of the building. The bio-hazard room, one fourth of an inch, open by the sprinkler head has been sealed with approved fire rated caulk. All other sprinkler heads have been inspected and all are sealed with no open areas. The TELS monitoring system will ensure that the sprinkler heads in every room are visually inspected by the Maintenance director or designee on a monthly basis. The reports from TELS will be reviewed by the Maintenance director every month. The Administrator will then bring these reports to the QA Committee to be monitored every month ongoing.</p> <p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety</p>	08/31/2015			

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K 0076 SS=E	<p>the exit on the 200 hall during an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 08/10/15 between 10:15 a.m. and 12:20 p.m., the exit discharge path for the 200 hall exit was obstructed by five wheel chairs and two Hoyer lifts. These items were in the corridor at 10:15 a.m. and were in the same location at 12:20 p.m. Based on an interview at the time of observation, the Maintenance Director acknowledged the wheel chairs and Hoyer lifts in the hall. Based on review at 9:45 a.m., with the maintenance Director, the facility ' s fire safety plan did not address the relocation of wheeled equipment located in the corridors during a fire or similar emergency. During the exit interview, the administrator stated the lifts are kept in the hall during the day but did not have a waiver stating the reason for storage of the lifts in the corridor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>of the residents, nor are they of such character so as to limit our capability to render adequate care. 25 residents of 85 had the potential to be affected. Of the wheelchairs mentioned all were wheelchairs curenly in use by the residents. Facility is currently requesting a waiver that would allow lifts and resident transport chairs to stay on the hallway for safety and quality of care for residents. These lifts would all be located on one side of hall for residents to be able to comfortably pass meeting the 60 inch requirement. All staff have been in-serviced on wheelchairs and lifts in the hallway per regulations, and where to keep wheelchairs not in use. Unit Managers/Maintenance will monitor hallways to make sure wheelchairs and lifts in hallway are on one side and moved with resident care. Any wheelchairs not being used by a resident will be stored in the proper location. Daily rounds on business days will be completed for one week. Weekly audit tool will be completed x 4 weeks, and then monthly ongoing. Administrator will review audit sheets monthly. QA Committee will review the audit tools monthly ongoing.</p>		

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Bldg. 01	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in the oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice was not in a patient treatment area but could affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 08/10/15 at 12:05 p.m., on a shelf in the oxygen storage room there was an unsupported cylinder of compressed oxygen. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.</p>	K 0076	<p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. No residents had the potential to be affected as the oxygen room is located in a secured and locked area, in a corridor leading to the outside of the building. The oxygen cylinder has been relocated to the proper location and secured. Inspection of the oxygen room noted no other concerns. The maintenance director/designee will audit the oxygen room one time a week for four weeks, and then monthly ongoing. The audit form will be reviewed by the Administrator monthly and presented to the QA Committee every month ongoing.</p>	08/31/2015			

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K 0000 Bldg. 02	<p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/10/15</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>At this Life Safety Code survey, Mason Health Care 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) and 410 IAC 16.2. The 2004 addition of the 400 Hall and the Therapy room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire</p>	K 0000					

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	<p>alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 115 and had a census of 85 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached sheds providing facility services including acitivity supplies, maintenance supplies and housekeeping supplies that were not sprinklered.</p>			