

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2015
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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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: 09/28/15</p> <p>Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980</p> <p>At this Life Safety Code survey, Riverbend 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), Chapter 19, Existing 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, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 32 at the time of this survey.</p>	K 0000	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider with the statement of deficiencies. This Plan of Correction is prepared and/or executed because it is required by provision of Federal and State regulations.</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 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies.</p> <p>Quality Review completed 09/29/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 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</p>	K 0025	<p>1.An approved Fire Barrier sealant will be applied to the areas of penetration in the attic above the nurses' station, in the attic of the east smoke barrier wall, above the ceiling tiles, and in the attic of the east smoke barrier wall. The approved fire barrier sealant will be applied to the smoke barriers in the ceiling of alcove in room 103 and in the ceiling of the alcove above room107. The fire barrier sealant will be applied to areas of penetration surrounding the wires</p>	10/28/2015			

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	<p>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 26 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Director of Maintenance on 09/28/15 between 11:40 a.m. and 12:15 p.m., the following smoke barrier walls had unsealed penetrations or penetrations sealed with an un-rated material:</p> <p>a) in the attic of the nurses' station smoke barrier wall there were two unsealed two inch penetrations in a metal pipe chase, and a two inch unsealed crack above a water line.</p> <p>b) above the ceiling tiles and in the attic of the nurses' station smoke barrier wall there were three penetrations filled with white and gray caulk.</p> <p>c) in the attic of the east smoke barrier wall there was a two inch unsealed crack above an air duct.</p> <p>d.) above the ceiling tiles and in the attic of the east smoke barrier wall there were five penetrations filled with white and gray caulk.</p>		<p>and conduits in the ceiling of the communications room. The fire barrier sealant will be applied to the area of penetration around the sprinkler head in the west lounge area.</p> <p>2. Maintenance director will inspect all resident rooms, lounges, doors, windows, offices, closets, kitchen and therapy areas to ensure smoke barriers are protected to maintain smoke resistance.</p> <p>3. Maintenance Director will be in-serviced on policy and procedure for fire safety and maintaining documentation that fire stop applications met requirements for use in penetration of fire stop system. Maintenance director will perform monthly fire inspections and immediately address issues identified. Quarterly fire inspections will be conducted by outside fire safety system provider.</p> <p>4. Results of rounds and inspections will be reviewed monthly by QA committee. Monthly and quarterly inspections will continue as an ongoing quality assurance measure.</p>		

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	<p>Based on interview at the time of observation, the Director of Maintenance acknowledged and provided the measurements of the penetrations. Also, the Director of Maintenance did not know if the white or gray caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems.</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 were maintained to provide a one half 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 21 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Director of Maintenance and the accounts manager on 09/28/15 between 09:00 a.m. and 11:30 a.m., the following ceiling smoke barrier had unsealed penetrations or penetrations sealed with an un-rated material:</p> <p>a) in the ceiling of the alcove in room 103 there was an unsealed penetration</p>			

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K 0046 SS=C	<p>around a cable wire measuring a quarter of an inch in size.</p> <p>b) in the ceiling of the alcove in room 107 there was an unsealed crack measuring a four inches in length.</p> <p>c) in the ceiling of the communications room there were 5 unsealed penetrations around a conduits and wires measuring one inch to a quarter of an inch in size.</p> <p>d) in the ceiling of the communications room there were 20 penetrations around wires and conduits filled with white caulk.</p> <p>e) in the ceiling of the sprinkler riser room there were 18 penetrations around wires and conduits filled with a white caulk.</p> <p>f) in the ceiling of the west lounge there was one penetration around a sprinkler head filled with a white caulk.</p> <p>Based on interview at the time of observation, the Director of Maintenance acknowledged and provided the measurements of the penetrations. Also, the Director of did not know if the white caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>			

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Bldg. 01	<p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 2 of 2 battery-operated emergency light fixtures for the generator of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Director of Maintenance on 09/28/15 from 10:00 a.m. to 12:08 p.m., battery-operated emergency lights were observed by the generator and in the generator electrical room. Based on record review with Director of Maintenance at 10:28 a.m., the "TELS Logbook " showed documentation for the 30 second monthly test but lacked</p>	K 0046	<p>1.A 90 minute test of the battery operated emergency lights for the generator and in the generator electrical room will be conducted. Documentation will be maintained of the 90 minute test for battery operated emergency lights.</p> <p>2.All residents have the potential to be affected.</p> <p>3.Maintenance Director will be educated on facility preventative maintenance for emergency lighting, which includes testing and documenting scheduled maintenance in preventative maintenance system, TELS. TELS system has been updated to include the 90 minute test for the battery operated emergency lights.</p> <p>4.Maintenance director or designee will perform preventative maintenance tasks for emergency lighting and record in PM system, TELS, per policy. Monthly review of preventative maintenance, including life safety standards, will be reviewed monthly by QA, and will continue as an ongoing QA measure.</p>	10/28/2015

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K 0050 SS=F Bldg. 01	<p>documentation of a 90 minute annual test of the battery operated emergency lights. Based on an interview during records review, the Director of Maintenance stated an annual test for the two battery-operated emergency lights occurred last year but could not provide any paper work or documentation to show the 90 minute test.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the</p>	K 0050	<p>1.Facility is unable to locate or provide documentation of a fire drill for second shift for fourth quarter of 2014. Maintenance Director or designee will conduct monthly fire drills on each shift</p> <p>2.Maintenance director or designee will conduct a monthly fire drill on each shift to ensure staff can carry out fire safety procedures for all residents.</p> <p>3.All staff will participate in</p>	10/28/2015

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K 0130 SS=F Bldg. 01	<p>"Southwest Allen County Fire District Fire Dill" with the Director of Maintenance on 09/28/15 at 10:30 a.m., there was no record of a second shift fire drill for the fourth quarter of 2014. Based on an interview with the Director of Maintenance at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke alarms installed in 40 of 40 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during records review with the Director of Maintenance on 09/28/15 at 10:10 a.m., it was noted the resident rooms in the Health Care</p>	K 0130	<p>monthly fire drills. Records of monthly fire drills will be maintained by the Maintenance Director. Maintenance director will notify fire alarm monitoring company of monthly drills.</p> <p>4.Results of fire drills will be reviewed by QA committee monthly for 6 months, then quarterly times 2; to ensure appropriate actions were taken during fire drills or if corrective action or additional training is needed. QA will determine the need for continued monitoring or corrective action.</p> <p>1. Maintenance director will clean and test each smoke in all resident rooms. 2. All battery operated smoke detectors in resident rooms will be tested and cleaned monthly to ensure they are working properly by Maintenance Director. 3. Maintenance director will be in-serviced on testing, cleaning, and recording battery operated smoke detectors. Documentation of preventative maintenance will be maintained in TELS system. 4. Maintenance director will provide monthly TELS report to QA committee for review of fire safety reports, which includes testing and cleaning of battery operated smoke detectors. Fire safety reports will be reviewed monthly in QA for 6 months, then</p>	10/28/2015			

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K 0147 SS=B Bldg. 01	<p>building had battery operated smoke alarms, but no documentation of a battery test or cleaning for the alarms was available for review. Based on an interview during record review, the Director of Maintenance acknowledged there was no available documentation to confirm a monthly function test or cleaning was conducted on the battery operated smoke alarms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could 14 residents in the south hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0147	<p>quarterly times 2; to ensure appropriate actions were taken regarding fire safety standards.</p> <p>1.Maintenance director replaced the cover to the electrical junction box in the area above the ceiling tiles. 2.All electrical rooms and storage areas were inspected by maintenance director to ensure appropriate covers were in place for electrical junction boxes and wiring secured as appropriate. 3.Maintenance director will be re-educated on ensuring wiring and equipment is maintained in safe operating condition. 4.Maintenance director or designee will complete daily rounds and following contractor visits and/or inspections; to ensure wiring and equipment is maintained in safe operating condition. Rounds will be</p>	10/28/2015

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	<p>facility with the Director of Maintenance on 09/28/15, an above the ceiling tiles near the south smoke barrier wall there was a 5 by 5 inch electrical junction box with numerous wire connections jutting out of the box without a cover. Based on an interview during record review, the Director of Maintenance acknowledged the electrical junction box was without a cover.</p> <p>3.1-19(b)</p>		<p>reviewed in QA monthly by QA for 6 months, then quarterly times 2; to ensure appropriate actions were taken regarding fire safety standards.</p>		