

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
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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: 12/12/13 and 12/13/13</p> <p>Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Byron Health 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 four story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in areas open to the corridors. Battery</p>	K010000	<p>This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</p>	
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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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K010018 SS=E	<p>operated smoke detectors have been installed in all resident rooms. The facility has a capacity of 191 and had a census of 99 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/23/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the</p>	K010018	What corrective action(s) will be accomplished for those residents	02/07/2014

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	<p>facility failed to ensure 1 of 1 sets of swap shop corridor doors and 1 of 2 sets of emergency generator room corridor doors closed and latched into the door frame. This deficient practice affects approximately 6 residents in the therapy hall.</p> <p>Findings includes:</p> <p>Based on observation with the Director of Plant Operations on 12/12/13 from 12:53 p.m. to 1:00 p.m., the set of corridor doors entering the swap shop and one set to the emergency generator room on the therapy hall had one door in each set equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Director of Plant Operations at the time of observations.</p> <p>3.1-19(b)</p>		<p>found to have been affected by the deficient practice? The manual latching devices in both locations will be replaced with an automatic latching system. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken? Six residents have the potential to be affected by the doors not having an automatic latching system. The latches will be changed from manual to automatic. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The manual latching system will be changed to an automatic latching system; therefore, one the work is completed, this deficiency will not recur. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Once the automatic system has been installed, monitoring will not be necessary as it will be a permanent installation.</p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 18 corridors were maintained to provide adequate headroom. LSC 7.1.5 requires the means of egress shall be designed and maintained to provide adequate headroom as provided in other sections of this Code and shall not be less than 7 feet 6 inches with projections from the ceiling not less than 6 feet 8 inches nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 feet 8 inches. This deficient practice could affect any residents, staff and visitors in the facility who would use these basement corridors.</p> <p>Findings include: Based on observations with the director</p>	K010038	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The cited corridors are not corridors resident are required to use and are not part of corridors for egress from the building. This facility has been granted a waiver for many years and we will once again request the waiver. All of the cited doors will have the independent dead bolt and knob replaced with lockable door knobs. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. The ceiling heights have been this ways for decades and no resident has been adversely affected. This practice would not have the potential of affecting residents. The aforementioned areas are locked when staff is not present for the safety of the residents. These doors are not a fire exit, so emergency entrance to these rooms is not needed.</p>	02/07/2014	

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	<p>of plant operations on 12/12/13 from 12:53 p.m. to 3:15 p.m. and on 12/13/13 from 9:40 a.m. to 12:00 p.m., the following areas in the basement failed to provide adequate headroom:</p> <p>a. The basement ceiling height in the east-west corridor measured six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along the 70 foot corridor that measured five feet seven inches from the floor. This was acknowledged by the director of plant operations at the time of observations.</p> <p>b. The ceiling height at the south basement corridor smoke barrier wall measured five feet nine inches. Additionally, there was a pipe protruding below the ceiling which ran along the center basement corridor that measured six feet from the floor and the north-south corridor intersection had pipes protruding below the ceiling which ran along the corridor that measured five feet nine inches from the floor. This was acknowledged by the director of plant operations at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 therapy room corridor exit doors and 4</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The ceiling area cited is in the basement area and was built in the 1920's There is no economically feasible way to raise the ceiling height. The useful life of the building is only 2 -4 years. Once all of the locks have been changed, the systemic change will have taken place and will be a permanent solution. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. We will be requesting a waiver. Please see attachment #1. The Director of Maintenance, or his designee, will ensure the locks have been changed and keys given to the appropriate staff.</p>	

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	<p>of 17 clinic hall corridor exit doors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 6 residents in the therapy room and any number of residents in the clinic hall.</p> <p>Findings include:</p> <p>Based on observation with director of plant operations on 12/12/13 between 1:00 p.m. and 1:18 p.m., the following corridor doors were equipped with an independent dead bolt; the door entering the therapy room where the parallel bars are located, and in the clinic hall; the optometry clinic, the podiatry clinic and both doors entering the old pharmacy. This was acknowledged by the directory of plant operations at the time of observations.</p>				

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K010161 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2</p> <p>Based on observation and interview; the facility failed to ensure 6 of 6 elevator equipment rooms were provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room.</p> <p>Findings include:</p>	K010161	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Bids have been obtained and signed. The work has been scheduled and the shunt trip for the elevators will be installed. Please see attachment #2 & #3 How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the lack of shunt trips in the identified areas. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A bid has been obtained and signed for installing shunt trips in the cited areas. The work will be scheduled and completed as quickly as the contractor can accomplish the needed work. How the corrective action(s) will be monitored to ensure the deficient practice will not recur</p>	02/07/2014	

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	<p>Based on observations with the director of plant operations on 12/12/13 from 1:26 p.m. to 2:15 p.m. and on 12/13/13 from 9:40 a.m. to 11:24 a.m., all six elevator equipment rooms were provided with a sprinkler head. Based on interview at the time of observations, the director of plant operations confirmed a shunt trip for the elevator machine equipment was not provided.</p> <p>3.1-19(b)</p>		<p>i.e., what quality assurance program will be put into place. Once the shunt trip systems are installed, the corrective action will have been completed. It will then become part of system wide elevator testing program conducted as part of our fire inspection process as required by law.</p>	