

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
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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: 06/16/16</p> <p>Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860</p> <p>At this Life Safety Code survey, Betz Nursing Home 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 (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 battery operated smoke detectors in the resident rooms. The facility has a capacity of 115 and had a census of 106 at the time of this survey.</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

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 the residents have customary access were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 06/17/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 8 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 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</p>	K 0025	<p>It is the practice of this provider to ensure that ceiling smoke barriers provide a one half hour fire resistance rating. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The duct workpenetrating the fire barrier wall in the 700 and 200 hall attics was sealed using fire resistant caulkingby the maintenance supervisor on 7-5-2016 The wires penetrating the 200 hall attic were sealed using fire resistant caulkingby the maintenance supervisor on7-5-2016. All other smoke barriers were inspected by the maintenance</p>	07/05/2016

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	<p>practice could affect up to 40 residents in 4 of 9 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor from 12:00 p.m. to 12:35 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the smoke barrier wall by room 701 there was an unsealed one inch penetration around a duct.</p> <p>b) In the attic of the smoke barrier wall by room 200 there was an unsealed half of an inch penetration around a wire.</p> <p>c) In the attic of the smoke barrier wall by room 200 there was an unsealed one inch penetration around a duct.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>		<p>supervisor/designee to ensure no other unfilled penetrations to the fire barrier walls exist. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will betaken? Forty residents have the potential to be affected by the alleged deficient practice. All penetrations have been repaired to meet this code. Maintenance supervisor/designee or contracted vendor inspected/ensured that all ceiling barriers provide the appropriate fire resistance for one half hour. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Preventive maintenance schedule is implemented that will include checking access panels, and verifying penetrations of ceiling smoke barriers are properly sealed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will monitor per facility preventive maintenance manual monthly schedule. Any needed repairs will be completed immediately to ensure compliance. Findings will be reported for 3 months to the safety committee, and quarterly thereafter for 3 additional quarters.</p>		

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K 0038 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 1 of 11 exit doors were accessible with the proper signage. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect 23 residents on the 500 hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Supervisor on 06/16/16 at 11:02 a.m., the exit doors from the 500 lounge was equipped with an electromagnetic lock that released after pushing the door for 15 seconds but lacked the proper signage. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p>	K 0038	<p>It is the practice of this provider to ensure that all exit doors are readily accessible with proper signage. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee installed the signage that reads 'PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS' on the 500 hall lounge door. All other doors and hallways were assessed for compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents had the potential to be affected by the alleged deficient practice. Maintenance supervisor/designee installed the proper signage. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance supervisor/designee will provide a monthly safety inspection report will verify that signage is in place on all doors equipped with electromagnetic locks that release after pushing the door for 15 seconds. How will the corrective action be</p>	06/29/2016			

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K 0062 SS=F Bldg. 01	<p>3.1-15(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 06/16/16 at 09:45 a.m., the P.I.P.E. Inc. internal pipe letter indicated an internal inspection of the pipes had been completed on 10/07/2010. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to show an</p>	K 0062	<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will report any negative findings immediately to executive director and also will report at monthly safety meeting.</p> <p>It is the practice of this provider to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The internal pipe inspection that is to be conducted every 5 years has been scheduled the the vendor. This vendor will also replace the gauge for the 500 hall riser. The 7 sprinkler heads that were found to have dust and lint on them in the laundry room have been cleaned All remaining sprinkler heads were checked by maintenance for compliance. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective</p>	07/11/2016	

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	<p>internal pipe inspection was completed in the last five years.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to clean and maintain 7 of 7 sprinklers in the laundry room. 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 can affect up to 5 residents outside the laundry.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 06/16/16 at 11:15 a.m., seven automatic sprinklers in the laundry room where completely covered with dust and lint. Based on interview, this was acknowledge by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 7 sprinkler gauges on the 500 hall riser were tested every five years. NFPA 25,</p>		<p>action will be taken? Five residents had the potential to be affected by the sprinkler heads with dust/lint on them and all residents had the potential to be affected by system check being 8 months past the due date. The contracted vendor has been scheduled to perform the test on 7/11/2016. Maintenance supervisor/designee examined all remaining sprinkler heads for compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance supervisor/designee will observe sprinkler heads in laundry weekly and clean as needed. Contracted vendor will provide appropriate inspection report for facility files which will assure compliance for the next five years. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool will be completed quarterly. The tool will be reviewed at the applicable safety meeting as well as the CQI meeting</p>		

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K 0130 SS=E Bldg. 01	<p>Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 06/16/16 at 11:17 a.m., one of the sprinkler gauges of the 500 hall sprinkler riser had a date of 2009. Based on an interview at the time of observation, the Maintenance Supervisor was unable to verify if the sprinkler gauge had been calibrated or replaced in the last five years.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code</p>	K 0130	It is the practice of this provider to ensure care and maintenance of rollingfire doors in accordance with NFPA 80. (inspected and tested annually) What corrective action will be accomplished for those residents foundto have been affected by the deficient practice?Vendor has been scheduled to perform the inspection/maintenance on the	07/08/2016			

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	<p>exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 35 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 06/16/16 at 10:45 a.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on records review at 10:55 a.m., no annual inspection was available for review to show an annual inspection was completed on the rolling fire door. Based on interview at the time of records review, the Maintenance Supervisor stated the inspection was completed but could not find the proper inspection paper work.</p> <p>3.1-19(b)</p>		<p>rolling fire door 07-11-2016.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents could potentially be affected by the alleged deficient practice. Fire door will be inspected/maintained on 7/11/16 and the appropriate tag will be put in place on said door. Also, inspection paperwork will be obtained and filed at facility for future reference. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance supervisor will get preventive maintenance will be scheduled annually to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will set a reminder for scheduling on computer. Environmental safety CQI tool will be completed quarterly and results will be reviewed at the next scheduled monthly safety meeting.</p>		