

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2012
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NAME OF PROVIDER OR SUPPLIER ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
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K0000	<p>A Life Safety Code Recertification, State Licensure, and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/19/12</p> <p>Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Royal Oaks Health Care and Rehabilitation 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</p>	K0000	Royal Oaks is requesting a desk review of the plan of correction rather than an on site revisit. Thank You, Susan Baker, RN, DNS	

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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	<p>determined to be of Type III (211) construction and was fully sprinklered with the exceptions cited at K- 56. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 207 and had a census of 176 at the time of this survey. The 800 hall is currently unoccupied.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage. The facility was in compliance with state law with regard to smoke detector coverage.</p> <p>All areas providing facility services were sprinklered. All areas providing facility services were sprinklered, except a detached employee smoke hut.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0021 SS=F	<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. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 15 of 15 smoke barrier door sets were held open only by devices which allowed the doors to close automatically upon activation of the fire alarm system. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/19/12 at 3:20 p.m., the fire alarm was tested by the maintenance director. Magnets holding smoke barrier and fire doors open failed to release the doors, and each remained wide</p>	K0021	There were not any residents or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the facility contracted with Tri State Fire Protection to ensure magnets holding smoke barrier and fire doors automatically close all such doors by zone throughout the facility upon activation of the required manual fire alarm system; local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system, and the automatic sprinkler system, if installed. All above repairs were completed on November 19, 2012. Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure will be checked monthly by the	12/19/2012			

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	<p>open. A second test of the fire alarm resulted in a second failure of the doors to close. The maintenance director agreed at the time of observations, the doors should have closed upon activation of the fire alarm system.</p> <p>3.1-19(b)</p>		<p>Director of maintenance to ensure that the deficient practice does not occur. Director of Maintenance is responsible to validate proper working order of above equipment. Director of Maintenance will report validation monthly at facility PI meeting. Date of compliance is December 19, 2012.</p>		

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K0022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 paths in the exit means of egress from the 500 and 600 halls were clearly identified. This deficient practice affects visitors, staff and 34 residents on the 500 and 600 halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/19/12 at 3:15 p.m., exit egress to the public way required passing through gates in a six foot tall wooden fence. Two gates were of the same material as the fencing and were not clearly distinguishable from the fence. No exit signs were posted. The maintenance director said at the time of observation, the signs had deteriorated, come off, and had not been replaced.</p> <p>3.1-19(b)</p>	K0022	<p>There were not any residents or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the facility has placed proper exit signage where exit egress to the public way requires passing through gates in a six foot tall wooden fence. Signage for access to exits will be checked monthly by the Director of Maintenance to ensure that the deficient practice does not occur. Director of maintenance is responsible to validate proper signage is readily apparent to the occupants. Director of Maintenance will report validation monthly at facility PI meeting. Date of compliance is December 19, 2012.</p>	12/19/2012	

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K0025 SS=E	<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>Based on observation and interview, the facility failed to ensure openings through 8 of 14 smoke barriers were sealed with a material to provide the 1/2 hour smoke resistance of the smoke barrier. 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 practice could affect visitors, staff and 155 residents on the 100, 200, 300, 400, 600, 700, 900 and north, main hall.</p>	K0025	<p>There were not any resident or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the unsealed gaps where smoke barriers had been penetrated above the laid in ceilings by cables, conduit, pipe, ducts and wires: a. Near 401 by two and four inch pipes leaving one inch gaps b. On the 300 hall, half inch gaps by pipe c. On the 200 hall by conduit, a half inch gap d. On the 100 hall, a four by one inch cut out to allow the passage of conduit and pipe e. On the north, main hall, two inch gaps around four pipe penetrations f. On the 700 hall by a three inch water line, a half inch gap g. On the 900 hall, a half inch gap for two wire penetrations h. Near 602 where the seal did not extend to include the top of a duct and three conduits were unsealed All above repairs were completed in order to maintain smoke barriers with at</p>	12/19/2012			

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 11/19/12 between 12:15 p.m. and 3:30 p.m., unsealed gaps were evident where smoke barriers had been penetrated above the laid in ceilings by cables, conduit, pipe, ducts and wires:</p> <ul style="list-style-type: none"> a. Near 401 by two and four inch pipes leaving one inch gaps; b. On the 300 hall, half inch gaps by pipe; c. On the 200 hall by conduit, a half inch gap; d. On the 100 hall, a four by one inch cut out to allow the passage of conduit and pipe; e. On the north, main hall, two inch gaps around four pipe penetrations; f. On the 700 hall by a three inch water line, a half inch gap; g. On the 900 hall, a half inch gap for two wire penetrations; h. Near 602 where the seal did not extend to include the top of a duct and three conduits were unsealed. <p>The maintenance director agreed</p>		<p>least a one half hour fire resistance ratingSmoke barriers with at least a one half hour fire resistance rating will be checked monthly by the Director of Maintenance to ensure that the deficient practice does not occurDirector of maintenance is responsible to validate condition of smoke barriers. Director of Maintenance will report validation monthly at facility PI meeting.Date of compliance is December 19, 2012</p>				

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	<p>at the time of observations, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>			

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide complete sprinkler coverage for 2 of 15 smoke compartments in a one story building of Type III (211) construction. LSC 19.1.6.2 requires one story facilities of Type III (211) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 45 residents on the 100 and 300 halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/19/12 between 12:15 p.m.</p>	K0056	There were not any residents or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the facility contracted with Tri-State Fire Protection to install proper sprinkler protection for one shower stall in the common shower rooms on the 100 and 300 halls. Sprinkler protection will be checked monthly by the Director of Maintenance to ensure that the deficient practice does not occur. Director of maintenance is responsible to validate proper sprinkler protection. Director of Maintenance will report validation monthly at the facility PI meeting. Date of compliance is December 19, 2012.	12/19/2012	

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	<p>and 3:30 p.m., sprinkler protection was not provided for one shower stall in the common shower rooms on the 100 and 300 halls. The maintenance director acknowledged at the time of observation, the area was not protected by the other sprinklers in the rooms.</p> <p>3.1-19(b) 3.1-19(ff)</p>				

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K0147 SS=E	<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 and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 13 or more residents on the 600 hall and adjacent common area.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/19/12 at 3:15 p.m., a thick orange cord was found above the laid in ceiling above the doorway into the 600 hall. Upon closer inspection it was identified as an extension cord used to supply power to magnets designed to lock the doors. The maintenance director said at the time of observation, service contractors</p>	K0147	<p>There were not any residents or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the facility contracted with an electrician to remove the thick orange cord laid in the ceiling above the doorway into the 600 hall. Proper installation of fixed wiring was completed 11-28-12. Director of Maintenance will ensure that the deficient practice does not occur. Director of maintenance is responsible that proper electrical wiring and equipment is in accordance with NFPA70. Director of maintenance will monitor monthly and maintenance will validate monthly at facility PI meeting. Date of compliance is December 19, 2012</p>	12/19/2012			

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	<p>had installed the equipment, agreed it was not correctly done and he would have an electrician remedy the problem.</p> <p>3.1-19(b)</p>			