

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155822	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/16/2016
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NAME OF PROVIDER OR SUPPLIER  CEDAR CREEK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356
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K 0000  Bldg. 01	<p>An Life Safety Code Reertification 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: 06/16/16</p> <p>Facility Number: 013144 Provider Number: 155822 AIM Number: 201246060</p> <p>At this Life Safety Code survey, Cedar Creek Health Campus was found not in compliance with Requirements for Participation in Medicare, 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 18, New Health Care Occupancies. and 410 IAC 16.2.</p> <p>The one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in spaces open to the corridor and in resident rooms. The facility has the capacity for 58 and a census of 49.</p>	K 0000	<p>This plan of correction is submitted by Cedar Creek Health Campus in order to the alleged deficiencies sited during the Annual Life Safety Survey which was conducted on June 15, 2016. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. Please accept this plan of correction as the credible allegation of compliance.</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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K 0018 SS=E Bldg. 01	<p>All areas with customary resident access and providing facility services were sprinklered.</p> <p>Quality Review completed on 06/22/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Beauty Shop corridor doors had no impediment to latching into the door frame. This deficient practice could affect staff and at up to 15 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 06/16/16 at 11:14 a.m., the Administrator acknowledged the corridor door to the Beauty Shop had a rubber door stop that prevented the corridor door from closing and latching into the door frame.</p> <p>3.1-19(b)</p>	K 0018	<p>1. No ill effects noted for potential affected residents. 2. The door stopper has been removed and the automatic door closer removed so occurrence does not occur. 3. The door stopper removed and the automatic door closer removed. 4. Plant ops will ensure weekly during rounds that no door stopper used and beautician has been advised that no door stopper can be used. Plant ops will bring weekly audits to Quality Assurance monthly x 3 months or until 100% compliance.</p>	06/30/2016

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K 0025 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one 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 in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Administrator on 06/16/16 at 10:55 a.m., a one and one half inch and a quarter inch unsealed ceiling penetration around cables inside conduit was discovered in the Service Hall Mechanical room. Based on interview at the time of observation, the Administrator acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>	K 0025	<p>1. No ill effects noted to any staff.2. Plant ops resealed the ceiling smoke barriers to maintain a one hour fire barrier in mechanical room.3. Plant ops will audit weekly during rounds to ensure all ceiling smoke barriers are maintained with the one hour fire barrier.4. Plant ops will audit weekly and bring to Quality assurance monthly x 3 months until 100% compliance is obtained.</p>	06/30/2016			
K 0027 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non-</p>						

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K 0147 SS=D Bldg. 01	<p>rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC 18.3.7.8 requires rabbets, bevels, or astragals shall be required at the meeting edges. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 06/16/16 between 10:24 a.m. and 11:45 a.m., all four smoke barriers doors did not contain a rabbit, bevel, or astragal installed. Based on interview at the time of each observation, the Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p>	K 0027	<p>1. No ill effects noted to residents or staff 2. All four smoke barrier doors have had Siliconeal fire and smoke adhesive gasketing applied.3. During weekly testing of fire doors plant ops or their designee will check to ensure the doors close to form a smoke resistant barrier.4. Plant ops will bring weekly audits to Quality Assurance monthly to ensure compliance monthly x 3 or until 100% is obtained.</p>	07/01/2016
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	<p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 06/16/16 at 11:29 a.m. then again at 11:44 a.m., a surge protector was powering an oxygen concentrator in resident room 303. Then again, a surge protector was powering a refrigerator in the Medical Records office. Based on interview at the time of each observation, the Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0147	<p>1. No ill effects noted to residents or staff.2. The oxygen concentrator was immediately plugged into wall outlet. The refridgeator in medical records was immediately plugged into wall outlet.3. Plant ops or their designee will during preventive maintenance audits check to ensure all things are plugged in appropriately. 4. Plant ops will inservice staff on not using flexible cords as a substitute for fixed wiring to provide power equipment with a current draw. Plant ops will bring audits to Quality Assurance meeting monthly x 3 months or until 100% compliance.</p>	07/02/2016	