

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155361	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/18/2013
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NAME OF PROVIDER OR SUPPLIER  AMBER MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567
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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 Dates: 06/18/13</p> <p>Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Amber Manor 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping</p>	K010000		
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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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	<p>rooms. The facility has a capacity of 64 and had a census of 54 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached buildings, including a twenty foot by thirty foot garage used for the storage of maintenance supplies, extra beds, laundry supplies, and Christmas decorations, and an eight foot by ten foot storage barn used for the storage of holiday decorations.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/24/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010021 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 1 of 10 hazardous area room doors, such as a kitchen door, was only held open by a device which would allow the door to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 06/18/13 at 2:05 p.m. during a tour of the facility with the Director of Plant Operations (DPO), there</p>	K010021	All Dietary staff have been in-serviced that the doors to the kitchen may not be propped open. All doors to remain closed unless being utilized to transport food and supplies to the residents and dining area. DFS to check doors daily for 30 days to ensure the door is remaining closed, 3x weekly for 30 days, then 2x weekly for 30 days. Results to be reviewed during the safety portion of montly QA.	07/05/2013			

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	<p>was a set of double doors between the kitchen and Dining Room/corridor. Both doors were equipped with self closing devices, however, the west side door was held wide open with a door wedge between the floor and the bottom of the door which would not allow the door to close if the fire alarm system was activated. This was acknowledged by the DPO at the time of observation.</p> <p>3.1-19(b)</p>			

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K010029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of kitchen double doors, hazardous area doors, to the Dining Room/corridor, were equipped with positive latches and latched into their door frames.</p> <p>Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 06/18/13 at 2:05 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the set of double doors between the kitchen and Dining Room/corridor did not</p>	K010029	Removal of slide latch and instillation of the positive latch. All dietary staff have been in-serviced regarding the use and operation of the positive latch.	07/01/2013			

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	<p>automatically latch into the door frame. The only way to latch these doors into the door frame was to manually use the slide latch at the top of the doors. This was acknowledged by the DPO at the time of observation.</p> <p>3.1-19(b)</p>			

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete and accurate written fire safety plan for the protection of 54 of 54 residents, including staff response to battery operated smoke detectors in resident sleeping rooms, the use of the K-class fire extinguisher in the kitchen, and staff determination if a fire is small or large, thus addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the facility's "Fire" plan in the "Disaster Manual" on 06/18/13</p>	K010048	<p>On page 44 #19 of the disaster manual was updated to address resident room battery powered smoke detectors. All staff have been in-serviced in regards how to appropriately respond to resident room smoke detectors. A fire drill was conducted with the simulation that the alarm was sounding from the smoke detector in resident's rooms to ensure staff responded appropriately. Updated disaster manual page 44 #14 to not distinguish between major and minor fires but to treat all fires the same. All staff have been inserviced regarding the updated disaster manual. Updated the disaster manual to include K class fire extenguisher page 43 #8 to include instruction regarding appropriate use of a K class extenguisher. Sign posted in kitchen next to the K class extenguisher regarding as to when to use that paticular extenguisher. Dietary staff in-serviced in regards to proper use of K class extenguisher.</p>	07/12/2013			

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	<p>at 12:30 p.m. with the Director of Plant Operations (DPO) present, the Fire plan did not address staff reaction to resident room battery operated smoke detectors if activated, or the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Finally, #7 of the Fire plan stated "Extinguish the fire if small", and #14 stated "If the fire is a MAJOR fire (or a small fire that is out of control and unsafe to fight), evacuate all residents and staff from the affected compartment to another compartment of the building to these pre-assigned areas." Based on interview at the time of record review, the DPO acknowledged the Fire plan did not address staff response to battery operated smoke detectors in resident sleeping rooms, and the use of the K-class fire extinguisher located in the kitchen, plus it required staff to make the determination if a fire is large or small.</p> <p>3.1-19(b)</p>						

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K010056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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>1. Based on observation and interview, the facility failed to insure 1 of 5 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect 10 or more residents, as well as staff and visitors while in the Physical Therapy addition.</p> <p>Findings include:</p> <p>Based on an observation on 06/18/13 at 1:40 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the Janitor's Closet within the Physical Therapy area had two sprinkler heads within eight inches of each other. This was acknowledged by the DPO at the</p>	K010056	The contracted intallers "RC Fire" removed two of the four sprinkler heads in the therapy janitors closet. "RC Fire" was able to locate the sprinler head in the dining room closet that was missed during life safety tour. No POC was needed for this tag.	06/27/2013			

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	<p>time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 5 smoke compartments. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 06/18/13 at 1:55 p.m. during a tour of the facility with the Director of Plant Operations (DPO), the furnace closet within the Dining Room was not provided with sprinkler coverage. Based on interview at the time of observation, the DPO acknowledged there was no sprinkler coverage in the Dining Room furnace closet.</p> <p>3.1-19(b)</p>						