

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2015
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NAME OF PROVIDER OR SUPPLIER PILGRIM MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PLYMOUTH, IN 46563
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K 0000 Bldg. 01	<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: 11/30/15</p> <p>Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260</p> <p>At this Life Safety Code survey, Pilgrim Manor 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 54 at</p>	K 0000	<p>Please accept this Plan of Correction as my Allegation of Compliance with Title 42, CFR 483.70(a)</p> <p><u>Disclaimer:</u></p> <p>Pilgrim Manor does not believe and does not admit that any deficiency existed, either before, during or after the survey. Pilgrim Manor reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Pilgrim Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Pilgrim Manor does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Pilgrim Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>Pilgrim Manor reserves the right to</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 0025 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached buildings which are a maintenance building, a freezer and the laundry for the facility.</p> <p>Quality Review completed 12/03/15 - DA</p> <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 the penetrations caused by the passage of wire and/or conduit through 1 of 2 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</p>	K 0025	<p>modify policies/procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.</p> <p>The systemic changes will be in effect as of December 30, 2015.</p> <p>1.No resident was affected by this alleged deficient practice. 2.Twenty three (23) residents had the potential to be affected by this alleged deficient practice; however, none were affected. 3.The smoke barrier wall has been caulked with fire resistant caulking. The Maintenance Supervisor or designee will conduct monthly inspections of</p>	12/09/2015

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K 0029 SS=E Bldg. 01	<p>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 staff and at least 23 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Administrator on 11/30/15 at 1:30 p.m., the smoke barrier wall near resident room 35 had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a 3 cm by 4 cm. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <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</p>		<p>the smoke and fire barrier walls for any penetrations (See Exhibit 1). They will also check for penetrations after any wiring has been ran through the walls. The maintenance employee was in-serviced on how to check smoke/fire barrier walls for gaps or penetrations and complete the monthly Maintenance Schedule (See Exhibit 2)</p> <p>4. The Maintenance Supervisor will report his findings at the monthly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 3). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p>		

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	<p>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 the corridor door to 1 of 1 fuel-fired furnace rooms near resident room 20 and 1 of 4 kitchen doors, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff and at least 24 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/27/15 at 12:59 p.m. then again at 1:13 p.m., the Maintenance Supervisor and Administrator confirmed the corridor door entering the furnace room did not have a self closure on the door. Then again, the kitchen door entering the dish room, which is open to the kitchen, did not have a self closure on the door. Based on interview at the time of each observation, the Maintenance Supervisor and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>1.No resident was affected by this alleged deficient practice.</p> <p>2.Twenty-four(24) residents had the potential to be affected by this alleged deficient practice; however, none were affected.</p> <p>3.All rooms have been checked to ensure that all rooms that would be considered hazardous areas, have self-closures on them. The kitchen door and the furnace room door have self-closures on them as of 12-11-15.</p> <p>4.The Environmental Director was in-serviced on identifying hazardous areas and the need for self-closures (See Exhibit 4). Weekly the Environmental Director or designee will complete a weekly environmental round (See Exhibit 5). The weekly environmental rounds will include monitoring all rooms to ensure that all hazardous rooms have self-closures on them. The Environmental Director will report his/her findings at the Weekly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 7). The QAQI committee consists of: Director</p>	12/15/2015

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door set was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 26 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 11/30/15 at 11:45 a.m., the fire doors near resident room 28</p>	K 0044	<p>of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p> <p>1.No resident was affected by this alleged deficient practice. 2.Twenty-Six (26) residents had the potential to be affected by this alleged deficient practice; however, none were affected. 3.The fire door was repaired on 11-30-15, it now automatically closes and latches. 4.The maintenance employee has been in-serviced on fire and smoke barrier doors needing to latch (See Exhibit 2) Weekly the Maintenance Director or designee will check all fire and smoke barrier doors to ensure they latch (See Exhibit 6). The Maintenance Director will report his/her findings at the Weekly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 7). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director,</p>	12/09/2015	

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K 0045 SS=D Bldg. 01	<p>failed to close and latch when tested. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor and Administrator on 11/30/15 at 1:15 p.m., the battery operated emergency in the kitchen failed to illuminate when tested. Based on interview at the time of observation, the</p>	K 0045	<p>Maintenance Supervisor, Activity Director and Social Service Director.</p> <p>1.No resident was affected by this alleged deficient practice. 2.No residents had the potential to be affected by this alleged deficient practice. 3.The kitchen battery operated emergency light was replaced on 12-1-15. 4.Weekly the Maintenance Director or designee will check all battery operated emergency lights to ensure they illuminate (See Exhibit 8). The maintenance employee has been in-serviced on monitoring the battery operated emergency lights and completion of the check off form (See Exhibit 2). The Maintenance Director will report his/her findings at the Weekly QualityAssurance Quality Improvement (QAQI) meeting</p>	12/09/2015

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K 0050 SS=C Bldg. 01	<p>Maintenance Supervisor and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 8 of 8 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p>	K 0050	<p>(See Exhibit 7). The QA/QI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p> <p>1.No residents were affected by this alleged deficient practice. 2.Fifty-Four(54) residents had the potential to be affected by this alleged deficient practice. 3.The fire drill paperwork has been updated (See Exhibit 9) to include a place to document who at the fire monitoring company the facility talked to that confirmed they received the signal. It also includes the time the signal was received and what type of signal was received. 4.The Maintenance Supervisor completed an in-service on 12-9-15 (See Exhibit 2) with the</p>	12/09/2015

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K 0075 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on record review of titled "Monthly Fire Drill Report -Pilgrim Manor" with the Maintenance Supervisor and Administrator on 11/30/15 at 10:40 a.m., the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Maintenance Supervisor confirmed that no documentation was available to confirm verification of the transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection</p>	K 0075	<p>maintenance employee on how to complete the Monthly Fire Drill Report, including documenting who was called, the time they received the alarm and what type of alarm they received. The Maintenance Supervisor will report on the fire drill and if it was documented correctly at the Monthly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 3). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p> <p>1.No residents were affected by this alleged deficient practice. 2.Eleven (11) residents had</p>	12/17/2015	

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	<p>receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 East Lounge. This deficient practice could affect at least 11 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 11/30/15 at 11:55 a.m., one 30 gallon container of biohazardous soiled linen and one 30 gallon container of biohazardous trash were adjacent to one another under a sink with the top exposed by a hole cut in the countertop. Based on an interview at the time of observation, the Maintenance Supervisor and Administrator confirmed the containers were used for biohazardous waste and linen.</p> <p>3.1-19(b)</p>		<p>the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice.</p> <p>3.The soiled linen and trash containers are 16 gallon capacity, which if were completely full, would equal 32 gallons, which meets the requirements of the NFPA 101 life safety code. The bags in the containers were 30 gallon bags; however, they could not be filled over 16 gallons due to the container size. The bags will be changed to 12-16 gallon bags (See Exhibit 10).</p> <p>4.The Housekeeping staff have been in-serviced on the correct size bags to be used in areas without a self-closing door, not to exceed a total of 32 gallons (See Exhibit 11). Weekly the Environmental Director or designee will complete a weekly environmental round (See Exhibit 5). The weekly environmental rounds will include monitoring all rooms to ensure that all hazardous rooms have self-closures on them. The Environmental Director will report his/her findings at the Weekly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 7). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity</p>		

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K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the</p>	K 0130	<p>Director and Social Service Director.</p> <p>1.No resident was affected by this alleged deficient practice. 2.Twenty (24) residents had the potential to be affected by this alleged deficient practice; however, none were affected. 3.The fire barrier gap has been filled with fire rated caulk. The Maintenance Supervisor or designee will conduct monthly inspections of the smoke and fire barrier walls/construction for any penetrations or gaps (See Exhibit 1). 4.Maintenance was in-serviced on completing monthly inspections on the smoke and fire barrier walls and completing the form (See Exhibit 2). The Maintenance Supervisor will report his findings at the monthly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 3). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p>	12/15/2015			

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K 0144 SS=C Bldg. 01	<p>following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect at least 26 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor and Administrator on 11/30/15 at 1:37 p.m., the fire barrier traveled horizontal above the set of fire doors for five feet above the drop ceiling. When traveling from exterior wall to exterior wall, the fire barrier had an eighth inch gap when meeting perpendicular on both sides for five feet. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.</p>				

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	<p>3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Administrator on 11/30/15 at 11:03 a.m., the monthly generator testing indicated the highest amount of load put on the generator in twelve months was 24 percent. Based on interview at the time of record review, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition and confirmed that no documentation for an annual load bank</p>	K 0144	<p>1.No residents were affected by this alleged deficient practice.</p> <p>2.Fifty (54) residents had the potential to be affected by this alleged deficient practice; however, none were affected.</p> <p>3.The Emergency Generator Monthly Test Log has been updated (See Exhibit 12) to include a place to document the seconds for transfer time. There will be a load test completed prior to 12-30-15 and annually thereafter.</p> <p>4.The Maintenance Supervisor completed an in-service on 12-9-15 (See Exhibit 2) with the maintenance employee on how to complete the Emergency Generator – Monthly Test Log to include transfer time. The Maintenance Supervisor will report on the transfer time and when the annual load test is due and completed at the monthly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 3). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p>	12/29/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2015
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K 0147 SS=D Bldg. 01	<p>test was available for review.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Administrator on 11/30/15 at 11:03 a.m., the monthly testing forms failed to include the transfer time for nine months of the last twelve months of testing. Based on interview at the time of record review, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition and confirmed the aforementioned condition.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in</p>			

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	<p>accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 4 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 Maintenance Supervisor on 11/30/15 at 12:25 p.m. then again at 12:37 p.m., a surge protector powering another surge protector powering computer components in the Medical Records office. Then again a surge protector powering another surge protector powering computer components in resident room 3. Based on interview at the time of each observation, the Maintenance Supervisor and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K 0147	<p>1.No residents were affected by this alleged deficient practice.</p> <p>2.Fifty-four (54) residents had the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice.</p> <p>3.The surge protectors that were plugged into other surge protectors have all been removed. The junction box has been covered.</p> <p>4.The Environmental Director has been in-serviced on identifying what piggy backing surge protectors are and junction box covers (See Exhibit 4). Weekly the Environmental Director or designee will complete a weekly environmental round (See Exhibit 5). The weekly environmental rounds will include monitoring all rooms to ensure there are no piggy backing of surge protectors and no junction boxes that are not covered. The Environmental Director will report his/her findings at the Weekly Quality Assurance Quality Improvement (QAQI) meeting (See Exhibit 7). The QAQI committee consists of: Director of Nursing, Administrator, West and East Unit Managers, MDS Coordinator, In-Service Director, Business Office Manager, Dietary Manager, Environmental Director, Maintenance Supervisor, Activity Director and Social Service Director.</p>	12/15/2015	

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K 0000 Bldg. 02	<p>the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 11/30/15 at 12:10 p.m., there was exposed wiring in a junction box without a cover in the Electrical room. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by</p>	K 0000	Please accept this Plan of Correction as my Allegation of Compliance with	

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	<p>the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/30/15</p> <p>Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260</p> <p>At this Life Safety Survey, Pilgrim Manor 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 18, New Health Care Occupancies with 410 IAC 16.2-3.1-19.</p> <p>This one story addition was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 54 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>Quality Review completed 12/03/15 -</p>		<p>Title 42, CFR 483.70(a)</p> <p><u>Disclaimer:</u></p> <p>Pilgrim Manor does not believe and does not admit that any deficiency existed, either before, during or after the survey. Pilgrim Manor reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Pilgrim Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Pilgrim Manor does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Pilgrim Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>Pilgrim Manor reserves the right to modify policies/procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.</p>				

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	DA		The systemic changes will be in effect as of December 30,2015.		