

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 08/12/2015
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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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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: 08/12/15</p> <p>Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780</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) and 410 IAC 16.2. The existing portion of the facility which was surveyed using Chapter 19, Existing Health Care Occupancies.</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, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 64 and had a census of 57 at the time of this</p>	K 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on August 12, 2015</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before September 11, 2015</p> <p>We respectfully request paper compliance.</p>	

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 0029 SS=E Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</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 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 2 bathroom/shower rooms, which contained soiled linen containers with a capacity over 32 gallons, were equipped with self closing devices on the corridor doors. This deficient practice could affect any number of residents, as well as staff while in the West Shower room.</p> <p>Findings include:</p> <p>Based on observation on 08/12/15 at 11:30 a.m. during a tour of the facility with the Director of Plant Operations, the</p>	K 0029	<p>K 029</p> <p>The West Shower Room Door was equipped with a self closing device.</p> <p>Completion Date: 08/18/2015</p> <p>All residents and staff have the potential to be affected and therefore to ensure compliance in accordance with section 19.3.2.1 of Life Safety</p>	09/11/2015

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	West Shower room had three soiled linen and trash barrels over 32 gallons stored within. The door to the corridor was not provided with a self closing device. This was acknowledged by the Director of Plant Operations at the time of each observation. 3.1-19(b)		Code 101, all applicable doors were checked and have self closing devices in place and functioning. Completion Date : 08/18/2015 The systemic change is that all new construction or remodel of current facility will have self closing devices to all applicable areas. Completion Date: 09/11/2015 The Director of Plant Operations will implement checks of the self closing devices on all applicable doors on the daily walk through rounds to determine proper functioning of the device and document accordingly. The results of the walk through rounds will be forwarded to the QA committee times 6 months and quarterly thereafter for futher review and suggestions. Completion Date: 09/11/2015				
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on record review and interview, the facility failed to ensure 3 of 3 battery	K 0046	K 046	09/11/2015			

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	<p>powered light sets in the existing portion of the facility were tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Trilogy Plant Operations Manual on 08/12/15 at 10:20 a.m. with the Director of Plant Operations present, there was no documentation to show the three battery back up light sets were tested monthly in August, September, October, November, and December of 2014, and January, February, and March of 2015, plus, there</p>		<p>The three back up emergency exit lights were tested for 90 minute annual check and found to be functioning and documented.</p> <p>Completion Date: 08/19/2015</p> <p>All residents and staff have the potential to be affected and therefore to ensure compliance all applicable emergency lights were tested for 90 minutes and the results documented.</p> <p>Completion Date: 08/19/2015</p> <p>The systemic change is that a new Director of Plant Operations was appointed and inserviced regarding policy and documentation requirements. All checks and documentation has been present since his tenure began.</p> <p>Completion Date: 04/07/2015</p> <p>The Administrator will monitor for continued compliance during weekly meetings with Director of Plant Operations through review of all required documentation in</p>	

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K 0050 SS=F Bldg. 01	<p>was no documentation to show the three battery back up light sets were tested for ninety minutes annually within the past twelve months. This was confirmed by Director of Plant Operations at the time of record review.</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 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility.</p>	K 0050	<p>accordance with the Life Safety Code. The results of will be forwarded to the QA committee times 6 months and quarterly thereafter for futher review and suggestions.</p> <p>Completion Date: 09/11/2015</p> <p>K 050</p> <p>Fire Drills were performed as required in April, May, June, July</p>	09/11/2015

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	<p>Findings include:</p> <p>Based on review of the facility's fire drills in the Trilogy Plant Operations Manual on 08/12/15 at 9:15 a.m. with the Director of Plant Operations present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <ol style="list-style-type: none"> 1. Second shift (evening) and third shift (night) of the third quarter (July, August, and September) of 2014 2. First shift (day) of the first quarter (January, February, and March) of 2015 <p>This was confirmed by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b)</p>		<p>and August of 2015 and properly documented.</p> <p>Completion Date: 08/26/2015</p> <p>All residents and staff have the potential to be affected and therefore to ensure compliance Fire Drills were performed in April, May, June, July 2015 and additionally a fire drill on each shift in the month of August 2015 will be performed and properly documented.</p> <p>Completion Date: 08/19/2015</p> <p>The systemic change is that a new Director of Plant Operations was appointed and inserviced regarding policy and documentation requirements. All checks and documentation has been present since his tenure began.</p> <p>Completion Date: 04/07/2015</p> <p>The Administrator will monitor for continued compliance during weekly meetings with Director of Plant Operations through review of all required documentation in accordance with the Life Safety Code. The results of will be forwarded to the QA committee monthly times 6 months and</p>	

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K 0056 SS=E Bldg. 01	<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 an automatic sprinkler system that provided complete coverage in 1 of 6 smoke compartments. This deficient practice could affect any number of residents, as well as staff and visitors while near the Mechanical Room/Maintenance Room which was in the front smoke compartment.</p> <p>Findings include:</p>	K 0056	<p>quarterly thereafter for futher review and suggestions.</p> <p>Completion Date: 09/11/2015</p> <p>K 056 Two new sprinklers are scheduled to be installed in the Mechanical room/Maintenance Room Completion Date 9-11-2015 All residents and staff have the potential to be affected and therefore to ensure compliance two new sprinklers are scheduled to be installed Completion Date 9-11-2015 The systemic change is that the Director of Plant operations was in serviced regarding regulation of an automatic sprinkler system.</p>	09/11/2015

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K 0062 SS=E Bldg. 01	<p>Based on observation on 08/12/15 at 11:10 a.m. during a tour of the facility with the Director of Plant Operations, there were at least five sprinkler heads in the Mechanical Room/Maintenance Room, however, there was a three and a half foot by fifteen foot area behind a bank of tall electrical boxes that was not provided with sprinkler coverage. There were also shelves of combustible material stored in this area. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(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>Based on observation and interview, the facility failed to ensure ceiling tiles in 2 of 6 sprinklered smoke compartments were maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect any number of resident, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observations on 08/12/15</p>	K 0062	<p>Completion Date 9-11-2015 The Director of Plant Operations will complete daily checks of the fire sprinkler system with results forwarded to QA committee monthly times 6 months and quarterly thereafter for review and further suggestions/comments Completion Date 9-11-2015</p> <p>K 062</p> <p>All facility tiles and gaps in the sprinklered smoke compartments noted on the facility tour were replaced and/or repaired.</p> <p>Completion Date: 08/21/2015</p> <p>All residents and staff have the</p>	09/11/2015

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	<p>between 11:00 a.m. and 12:45 p.m. during a tour of the facility with the Director of Plant Operations, the following locations had missing ceiling tiles or penetrations through ceiling tiles:</p> <p>a. The Mechanical Room/Maintenance Room had missing ceiling tiles, and also gaps in many ceiling tiles around pipes, conduits, ducts and wires.</p> <p>b. The Mechanical Room in the south smoke compartment next to the resident TV area had five missing ceiling tiles.</p> <p>c. The kitchen furnace/water heater closet had one missing ceiling tile.</p> <p>This was acknowledged by the Director of Plant Operations at the time of each observation.</p> <p>3.1-19(b)</p>		<p>potential to be affected and therefore to ensure compliance all sprinklered smoke compartments throughout the facility were inspected and repaired as necessary.</p> <p>Completion Date: 08/21/2015</p> <p>The systemic change is all staff will be inserviced concerning ceiling tiles and importance of completing work orders if misplaced or in poor repair</p> <p>Completion Date: 04/07/2015</p> <p>The Director of Plant operations will complete daily rounds and observe ceiling tiles to ensure compliance with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for further review and suggestions</p> <p>Completion Date: 09/11/2015</p>				
K 0144 SS=C Bldg. 01	<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. 3.4.4.1. Based on record review and interview,</p>	K 0144				09/11/2015	

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	<p>the facility failed to ensure 1 of 1 emergency generators was inspected and exercised in accordance with NFPA 99. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log on 08/12/15 at 10:40 a.m. with the Director of Plant Operations present, the generator log form documented the generator was tested monthly under load, however, there was no documentation on the form that showed the generator cool down time following the load test. During an interview at the time of record review, the Director of Plant Operations confirmed the monthly generator log did not include documentation of the cool down time being recorded.</p> <p>3.1-19(b)</p>		<p>K 062</p> <p>All facility tiles and gaps in the sprinklered smoke compartments noted on the facility tour were replaced and/or repaired.</p> <p>Completion Date: 08/21/2015</p> <p>All residents and staff have the potential to be affected and therefore to ensure compliance all sprinklered smoke compartments throughout the facility were inspected and repaired as necessary.</p> <p>Completion Date: 08/21/2015</p> <p>The systemic change is all staff will be inserviced concerning ceiling tiles and importance of completing work orders if misplaced or in poor repair</p> <p>Completion Date: 04/07/2015</p> <p>The Director of Plant operations will complete daily rounds and observe ceiling tiles to ensure compliance with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for further review and suggestions</p>				

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K 0000 Bldg. 02	<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: 08/12/15</p> <p>Facility Number: 000252 Provider Number: 155361 AIM Number: 100267780</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) and 410 IAC 16.2. The 2014 addition consisted of resident rooms 201 through 209 which was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was</p>	K 0000	<p>Completion Date: 09/11/2015</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on August 12, 2015</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before September 11, 2015</p>	

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K 0050 SS=F Bldg. 02	<p>fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 64 and had a census of 57 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered.</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. 18.7.1.2 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include: Based on review of the facility's fire drills in the Trilogy Plant Operations Manual</p>	K 0050	<p>We respectfully request paper compliance.</p> <p>K 050 Fire Drills were performed as required in April, May, June, July and August of 2015 and properly documented. Completion Date: 08/26/2015</p>	09/11/2015

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	<p>on 08/12/15 at 9:15 a.m. with the Director of Plant Operations present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <ol style="list-style-type: none"> 1. Second shift (evening) and third shift (night) of the third quarter (July, August, and September) of 2014 2. First shift (day) of the first quarter (January, February, and March) of 2015 <p>This was confirmed by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b)</p>		<p>All residents and staff have the potential to be affected and therefore to ensure compliance Fire Drills were performed in April, May, June, July 2015 and additionally a fire drill on each shift in the month of August 2015 will be performed and properly documented.</p> <p>Completion Date: 08/19/2015</p> <p>The systemic change is that a new Director of Plant Operations was appointed and inserviced regarding policy and documentation requirements. All checks and documentation has been present since his tenure began.</p> <p>Completion Date: 04/07/2015</p> <p>The Administrator will monitor for continued compliance during weekly meetings with Director of Plant Operations through review of all required documentation in accordance with the Life Safety Code. The results of will be forwarded to the QA committee monthly times 6 months and quarterly thereafter for futher review and suggestions.</p> <p>Completion Date: 09/11/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155361	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2015
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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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K 0144 SS=C Bldg. 02	<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. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected and exercised in accordance with NFPA 99. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log on 08/12/15 at 10:40 a.m. with the Director of Plant Operations present, the generator log form documented the generator was tested monthly under load, however, there was no documentation on the form that showed the generator cool down time following the load test.</p>	K 0144	<p>K 062</p> <p>All facility tiles and gaps in the sprinklered smoke compartments noted on the facility tour were replaced and/or repaired.</p> <p>Completion Date: 08/21/2015</p> <p>All residents and staff have the potential to be affected and therefore to ensure compliance all sprinklered smoke compartments throughout the facility were inspected and repaired as necessary.</p> <p>Completion Date: 08/21/2015</p> <p>The systemic change is all staff will be inserviced concerning ceiling tiles and importance of completing work orders if misplaced or in poor repair</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155361	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2015
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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	During an interview at the time of record review, the Director of Plant Operations confirmed the monthly generator log did not include documentation of the cool down time being recorded. 3.1-19(b)		Completion Date: 04/07/2015 The Director of Plant operations will complete daily rounds and observe ceiling tiles to ensure compliance with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for further review and suggestions Completion Date: 09/11/2015		