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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 01/14/2013 |
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| NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058 |
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| K0000 | <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: 01/14/12</p> <p>Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mulberry Health 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility was determined to be</p> | K0000 | | |
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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>of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms in the original building are equipped with battery powered smoke detectors. The facility has the capacity for 159 and had a census of 137 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. An attached records storage building was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/22/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> | | | | |

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| K0017 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure an open use area in 1 of 11 first floor smoke compartments was separated from the corridor by smoke resistant walls, extending from the floor to the roof above, or met an exception. LSC 19.3.6.1, Exception # 6: Spaces other than patient sleeping rooms, treatment rooms and hazardous areas may be open to the corridor and may be unlimited in area provided: (a) The space and corridors which the space opens into in the same smoke compartment are protected by an electrically supervised automatic smoke detection</p> | K0017 | <p>K017 All residents who utilize this common area vending room have the potential to be affected. This facility will have installed in this space a smoke detector that is electronically connected to the facility's alarm system. Following installation it will be a part of all required monitoring checks provided by the contracted arrangement with a service company.</p> | 02/13/2013 |

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| | <p>system, and (b) Each space is protected by automatic sprinklers, or the furnishings and furniture within the area, in combination with all other combustibles within the area, are of such minimum quality and arrangement that a fully developed fire is unlikely to occur, and (c) The space does not obstruct access to required exits. This deficient practice could affect visitors, staff and 20 or more residents in main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 2:40 p.m., the door separating the vending room from the exit corridor in the main dining room smoke compartment had been removed leaving the space open to the corridor. The room had no smoke detector. The maintenance director said at the time of observation, he was unaware the room did not meet criteria allowing the opening to the corridor.</p> <p>3.1-19(b)</p> | | | | | | |

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| K0018 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 11 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 36 or more residents in the Physical Therapy and main dining room smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 between 12:15 p.m. and 3:00 p.m., the double door sets providing access to the physical therapy room,</p> | K0018 | <p>K018 All visitors, staff, and residents have the potential to be affected. The double doors in the maintenance shop and central supply have been as they are for over 40 years. They were latched into the frame during the survey. Both latches will be modified in a way that prevents them from ever being unlatched. The therapy door will have an external latching device placed on it so that they each will latch automatically into the frame.</p> | 02/13/2013 |

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| | <p>maintenance shop, and central supply room each required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch independently into the door frame.</p> <p>3.1-19(b)</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 1 of 4 doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects visitors, staff and 10 or more residents on the 100 wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 2:25 p.m., a glass door opened out onto a courtyard from the 100 wing lounge. The gate through the surrounding privacy fence was visible through the door. The maintenance director said the door was not part of a fire exit and agreed at the time of observation, the door</p> | K0022 | <p>K022 All residents who reside on this specific unit have the potential to be affected. This door will be marked in appropriate sized letters as "Not An Exit".</p> | 02/13/2013 | | | |

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| | <p>could be mistaken for a means of exit.</p> <p>3.1-19(b)</p> | | | |

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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 1 of 1 ceiling smoke barriers and 1 of 4 laundry room walls 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 10 or more residents on the 300 hall.</p> | K0025 | <p>K025 All residents who reside on this unit have the potential to be affected. Maintenance staff will properly seal the seven areas identified in the survey in the 300 mechanical room. Additionally they will also properly seal the area identified in the laundry room. Maintenance supervisor will monitor areas on an ongoing basis to ensure no additional areas develop.</p> | 02/13/2013 | |

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| | <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 01/14/13 at 12:50 p.m., seven unsealed ceiling conduit penetrations in the 300 hall electrical room gapped one half to one inch. The maintenance director said at the time of observation, he was unaware the gaps were not sealed.</p> <p>b. Based on observation with the maintenance director on 01/14/13 at 1:40 p.m., a gap between a duct and the wall separating the laundry from an exterior records storage room was filled with an expandable foam. The maintenance director agreed at the time of observation, the penetration had not been properly sealed.</p> <p>3.1-19(b)</p> | | | | | | |

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| K0038 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 large conference room exit doors equipped with magnetic locks was readily accessible for residents and anyone without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 says door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and any resident participating in activities held in the room with a capacity for 25 or</p> | K0038 | <p>K038 All visitors, staff, and residents using the areas identified in the survey have the potential to be affected. The code will be placed on the keypad next to the exit door from the large conference room. The means of exit egress will be properly maintained through the exterior exit door in the Therapy area. The expansion joints outside on the side walk will be modified to eliminate tripping hazards. Maintenance supervisor will monitor all exit doors with keypads on a weekly basis to ensure codes are posted. During weekly rounds Maintenance Supervisor will monitor all means of egress to ensure no obstructions. During monthly rounds Maintenance supervisor will monitor exterior sidewalks for new trip hazards. Maintenance Supervisor will report quarterly to the facility's QA committee identification of noncompliance for any of the above mentioned items being monitored.</p> | 02/13/2013 |

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| | <p>more occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 3:20 p.m., one door providing direct exit to the outside from the large conference room was identified by a sign, "emergency exit only." The door was locked. The maintenance director said at the time of observation the lock released upon activation of the fire alarm and the lock could be overridden by entering a code in the keypad located on the wall adjacent to the door. The code was not posted. The maintenance director had to enter codes two different times to get the correct override code. He said the code was frequently changed and he could not be sure which one worked. He agreed occupants of the room might need the code if the door failed to unlock upon activation of the fire alarm in an emergency.</p> <p>3.1-19(b)</p> <p>2. Based on observation and</p> | | | | |

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| | <p>interview, the facility failed to ensure 1 of 2 means of exit egress were free from obstruction such as furniture and equipment which would prevent its use. LSC 7.1.10 requires the means of egress be maintained free of obstructions which would prevent its use. This deficient practice affects visitors, staff and 4 residents in the physical therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 2:45 p.m., the exterior exit from the physical therapy room was identified by sign above the door. Access to the exit was gained through an eight by twelve foot passageway which opened into the physical therapy room. A utility table, overbed table, two carpet covered wood blocks measuring 12 by 24 by 3 inches, a stool, a hardback chair and a folding chair were arranged in a manner blocking exit egress. The maintenance director agreed at the time of observation, the 18 inch remaining clearance could impede</p> | | | |
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| | <p>use of the exit.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 2 of 14 exit discharges were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 20 or more residents on the 200 and 300 halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 between 1:00 p.m. and 2:00 p.m., the expansion joint across the concrete exit discharge surface outside room 325 gapped two inches; the expansion joint across the concrete exit discharge surface outside room 224 gapped</p> | | | | | | |

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| | and had level changes of one to two inches across. The maintenance director said at the time of observation, the surface irregularities had been noted and he planned to "fill them in." 3.1-19(b) | | | | |

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| K0050 SS=F | <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 fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the maintenance director on 01/14/13 at 3:15 p.m., there was no record of first and third shift fire drills for the last quarter of 2012. The maintenance supervisor acknowledged fire drill records were not complete and said he thought all fire drills were done.</p> | K0050 | <p>K050 All residents, staff and visitors have the potential to be affected in the event of an emergency. No action can be taken to correct the deficient practice as the time has already passed. Maintenance supervisor will be responsible for ensuring fire drills are completed on all shifts quarterly, and at least one annually coordinated with the local fire department. Maintenance Supervisor will report quarterly to this facilities Quality Assurance committee the validation of drills on every shift.</p> | 02/13/2013 | | | |

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| | 3.1-9(b) 3.1-51(c) | | | |

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| K0051 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> | K0051 | <p>K051 All visitors, staff, and residents have the potential to be affected. This facility will add to the fire monitoring control panel that has safely serviced the facility for 40 years an additional enunciator at one of the facility's nurses station for continues audible monitoring. The additional audible enunciator will be monitored on a routine basis for appropriate function by the contracted arrangement with a service company.</p> | 02/13/2013 | | | |

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| | <p>Based on observation with the maintenance director on 01/14/13 between 12:15 p.m. and 3:30 p.m., fire alarm control panels (FACP) were located in the basement, outside the reception desk and outside the Physical Therapy department. Each of the areas were not located where a trouble signal was likely to be heard outside of normal business hours. The maintenance director said at the time of observations, he relied on an off site monitoring station to call and notify him when trouble occurred on the system.</p> <p>3.1-19(b)</p> | | | |

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| K0056 SS=D | <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 sprinkler coverage for 1 of 1 exterior enclosures attached to the building. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice could affect 2 staff and any visitor in the vicinity.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 1:40 p.m., a six by seven foot wooden enclosure canopy was attached to the</p> | K0056 | <p>K056 All medical records stored in this area had the potential to be affected. This facility will have required sprinklers installed by a certified company in the exterior storage area so that medical records will be kept safe. The additional sprinkler will be included with all routine tests by the contracted arrangement with a service company.</p> | 02/13/2013 | | | |

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| | <p>building outside the laundry. The enclosure housed boxes of records. A wooden sliding door protected the door opening. Exposed wood studs supported the ceiling and wall panels. The maintenance director said at the time of observation, he thought the panels were masonite but was not certain. The area was not protected by sprinklers.</p> <p>3.1-19(b)</p> | | | |

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| K0064 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the kitchen was readily accessible. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice affects visitors and 4 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 1:35 p.m., the portable K-class fire extinguisher was located on a kitchen wall but could not be seen. The maintenance director pointed it out behind a five foot kitchen food service cart which stood in front of the extinguisher. The maintenance said at the time of observation, he had to fight with staff to keep the fire extinguisher</p> | K0064 | <p>K064</p> <p>All visitors, staff, and residents have the potential to be affected. Dietary supervisor will ensure K-class fire extinguisher is in plain sight at all times. Maintenance Supervisor will properly hang basement fire extinguisher back up. Maintenance supervisor will monitor both issues weekly while completing facility rounds to ensure ongoing compliance, and report quarterly to the facility's QA committee identification of noncompliance.</p> | 02/13/2013 |

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| | <p>free from obstructions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the north ground floor storage room was installed on a hanger, bracket, mounted in a cabinet or set on a shelf. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.6 requires that extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. NFPA 10 1-6.7 requires extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. This deficient practice could affect visitors and two or more staff in the basement maintenance equipment area.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 1:40 p.m., a fire extinguisher sat on a dehumidifier</p> | | | | |

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| | <p>in the basement maintenance equipment room. The maintenance director said, at the time of observation, "they knock it off all the time," pointing to a broken wall bracket behind a utility cart laden with bags of salt.</p> <p>3.1-19(b)</p> | | | |

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| K0076 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 cylinders of nonflammable gases in the oxygen supply storage room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and any resident in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the</p> | K0076 | <p>K076</p> <p>All visitors, staff, and residents have the potential to be affected. Maintenance Supervisor will install security chain in oxygen storage area so that all e-cylinders can be properly secured. Maintenance Supervisor will monitor weekly while completing facility rounds and report quarterly to the facility's QA committee identification of noncompliance.</p> | 02/13/2013 |

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| | <p>maintenance director on 01/14/13 at 1:55 p.m., one oxygen e-cylinder was stored without support in the oxygen supply storage room. The maintenance director said at the time of observation, the cylinder should not have been left standing this way.</p> <p>3.1-19(b)</p> | | | | |

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| K0130 SS=D | <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 service water heaters (SWH) had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 1:45 p.m., certificates of inspection posted for service water heaters #240564, #240561, #294069, #240563 and #294070 had each expired 04/15/12. The maintenance director said at the time of observation, the boilers had not been reinspected.</p> <p>3.1-19(b)</p> | K0130 | <p>K130</p> <p>All visitors, staff, and residents have the potential to be affected. Maintenance Supervisor will have all water heaters inspected to ensure compliance with regulatory requirements. Maintenance Supervisor will be responsible for reporting annually to the facility's QA Committee proper inspections for all water heaters.</p> | 02/13/2013 | |

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| K0143 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage and transfer rooms was arranged to allow oxygen transfer in the room with the door closed. This deficient practice affects visitors, staff and any resident in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 1:55 p.m., the oxygen transfer room in the original building was identified by the maintenance director. A</p> | K0143 | <p>K143 All visitors, staff, and residents have the potential to be affected. The oxygen tanks identified in the survey will be relocated to the facility's designated Oxygen storage location.</p> | 02/13/2013 | |

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| | <p>single light fixture in the room failed to illuminate when the light switch was turned on. The maintenance director agreed at the time of observation, portable oxygen tanks could not be filled with the door closed due to the lack of light.</p> <p>3.1-19(b)</p> | | | |
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| K0147 SS=D | <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 multitap adapters was not used as a substitute for fixed wiring. NFPA 70, the 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 visitors, 2 staff, and any resident in the laundry smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 2:20 p.m. a multitap outlet adapter was used to provide power to a radio and fan in the laundry. The maintenance director said at the time of observation, he didn't know the multitap adapter should not have been in use.</p> | K0147 | <p>K147 All visitors, staff, and residents have the potential to be affected. Maintenance Supervisor will install additional wall outlets so that power strips can be eliminated in laundry. Maintenance Supervisor will monitor during weekly rounds that power strips on not being utilized. Any issues of non-compliance will be immediately rectified.</p> | 02/13/2013 | | | |

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| K0000 | <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: 01/14/13</p> <p>Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mulberry Health 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) and 410 IAC 16.2. The 2004 addition of 14 rooms on the west 400 hall was surveyed with Chapter 18, New Health Care Occupancies.</p> | K0000 | | |

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| | <p>This facility 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 and spaces open to the corridors. Resident rooms on the 400 hall are equipped with hard wired smoke detectors. The facility has the capacity for 159 and had a census of 137 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. An attached records storage building was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> | | | |

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| K0050 SS=F | <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</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the maintenance director on 01/14/13 at 3:15 p.m., there was no record of first and third shift fire drills for the last quarter of 2012. The maintenance supervisor acknowledged fire drill records were not complete and said he thought all fire drills were done.</p> | K0050 | <p>K050 All residents, staff and visitors have the potential to be affected in the event of an emergency. No action can be taken to correct the deficient practice as the time has already passed. Maintenance supervisor will be responsible for ensuring fire drills are completed on all shifts quarterly, and at least one annually coordinated with the local fire department. Maintenance Supervisor will report quarterly to this facilities Quality Assurance committee the validation of drills on every shift.</p> | 02/13/2013 | | | |

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| | 3.1-9(b) 3.1-51(c) | | | | |

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| K0051 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the</p> | K0051 | <p>K051 All visitors, staff, and residents have the potential to be affected. This facility will add to the fire monitoring control panel that has safely serviced the facility for 40 years an additional enunciator at one of the facility's nurses station for continues audible monitoring. The additional audible enunciator will be monitored on a routine basis for appropriate function by the contracted arrangement with a service company.</p> | 02/13/2013 | | | |

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| | <p>maintenance director on 01/14/13 between 12:15 p.m. and 3:30 p.m., fire alarm control panels (FACP) were located in the basement, outside the reception desk and outside the Physical Therapy department. Each of the areas were not located where a trouble signal was likely to be heard outside of normal business hours. The maintenance director said at the time of observations, he relied on an off site monitoring station to call and notify him when trouble occurred on the system.</p> <p>3.1-19(b)</p> | | | |

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| K0074 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure a window curtain in 1 of 11 smoke compartments was rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient</p> | K0074 | <p>K074 All visitors, staff, and residents have the potential to be affected. The curtains identified in the 400 west oxygen storage area will be removed from the facility.</p> | 02/13/2013 | |

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| | <p>practice affects visitors, staff and 7 residents in the 400 west smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/14/13 at 3:10 p.m., flame resistance labeling was not found on the 400 west oxygen storage room window curtains. The maintenance director said at the time of observation, he had no evidence the curtains were flame resistant.</p> <p>3.1-19(b)</p> | | | | | | |

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| K0143 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was posted with a sign indicating oxygen transferring was taking place, provided with continuous mechanical ventilation to the outside, had ceramic or concrete flooring and separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 7 residents on 400 west.</p> <p>Findings include:</p> | K0143 | <p>K143 All visitors, staff, and residents have the potential to be affected. The oxygen tanks identified in the survey will be relocated to the facility's designated Oxygen storage location.</p> | 02/13/2013 | |

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| | <p>Based on observation with the maintenance director on 01/14/13 at 3:10 p.m., two liquid oxygen supply containers and a portable oxygen tank were were stored in a supply room beside the 400 west tub room. The door separating the room from the resident tub room was unrated, the room was not mechanically vented, no sign was posted to indicate the transfilling of oxygen in the room, the room was used for the storage of linens and plastic, paper and cardboard wrapped supplies on shelves lining two walls, and the floor was covered with vinyl tile. Staff # 1 was working on the 400 hall at the time observation. She said the room was used for the transfilling of portable oxygen tanks.</p> <p>3.1-19(b)</p> | | | |