

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2015
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NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 COMMERCE ST LOGANSPORT, IN 46947
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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: 11/30/15</p> <p>Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810</p> <p>At this Life Safety Code survey, Camelot Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (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 operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 65 at the time of this survey.</p>	K 0000	<p>Submission of the Plan of Correction does not constitute an admission of agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of 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 0025 SS=E Bldg. 02	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 12/02/15 - 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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 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 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</p>	K 0025	<p>1. No residents were affected. 2. All residents have the potential to be affected. 3. All smoke barrier walls were inspected and all deficiencies found were filled with a material capable of maintaining the smoke resistance of the smoke barrier. Preventative maintenance check list has been updated to include inspection of all fire walls. Maintenance supervisor and administrator will meet monthly to ensure inspections are completed and all deficiencies found were corrected and maintained.</p>	12/10/2015

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	<p>smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 40 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 between 12:00 p.m. and 12:20 p.m., the following smoke barrier walls had unsealed penetrations or penetrations filled with an un-approved material:</p> <p>a) above the ceiling tiles of the smoke barrier wall by room 16 there were ten penetrations filled with white and gray caulk around pipes.</p> <p>b) above the ceiling tiles of the smoke barrier wall by room 39 there was an unsealed half inch pipe sleeve.</p> <p>c. above the ceiling tiles of the smoke barrier wall by room 16 there were four unsealed quarter inch penetrations around pipes.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the penetrations and did not know if the white or gray caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems.</p>			

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K 0038 SS=E	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 10 residents in 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 at 10:11 a.m., in the ceiling of maintenance room there was an unsealed one inch penetration around a conduit and five penetrations filed with joint compound. Based on interview at the time of observation, the Maintenance Director acknowledge and provided the measurements of the penetration and acknowledge that the joint compound did not meet the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>						

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Bldg. 02	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exits was readily accessible at all times. LSC 18.2.2.2.4 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 requires 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 residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 35 residents using the activities exit if evacuated in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 at 11:45 a.m., outside in the courtyard there was a gate equipped with a pad lock. This gate was a part of the path of egress from the activities exit. The Maintenance supervisor tried to open the pad lock with the key available but the pad lock would not unlock. Based on</p>	K 0038	<p>1. No residents were affected. 2. All residents have the potential to be affected. 3. On 11/30/15 maintenance supervisor went to unlock gate during request of Life Safety surveyor and was unable to unlock he thought due to rust. After surveyor left the facility maintenance supervisor returned to the gate to rectify this situation and discovered he was attempting to unlock the gate for the surveyor using the wrong key. There were 3 keys on the key ring. Maintenance supervisor has now clearly marked all 3 keys on this key ring to ensure proper access to the lock on the gate will easily accomplished. 4. All keys in the facility for purpose of exit have been inspected and clearly marked.</p>	11/30/2015

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K 0066 SS=E Bldg. 02	<p>interview at the time of observation, the Maintenance Supervisor acknowledged the gate was a part of the path of egress and stated the lock must be rusted shut.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted for staff was maintained. This deficient practice was not in a resident care area, but could affect staff in the smoking area and staff</p>	K 0066	<p>1. No residents were affected. 2. No residents had the potential to be affected however staff had the potential to be affected. 3. Smoking areas were immediately cleaned as well as the area affected by the employee entrance. 3. Administrator and</p>	12/01/2015

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K 0075 SS=E Bldg. 02	<p>exiting through the staff entrance in the event of any emergency.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 at 10:55 a.m., the staff designated smoking area by the staff entrance was provided with a long neck approved container used for cigarette butt disposal, but there were at least 60 cigarette butts observed on the ground in the smoking area. Also, next to the staff entrance there were at least 25 cigarette butts in a pile of leaves. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</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>maintenance supervisor will inspect all potential areas affected 5 times a week for a month and then weekly thereafter. All staff have been reeducated on the smoking area policy and the disposal of cigarette butts. 4. Quality assurance audit of the smoking areas as well as employee entrance has been implemented and will be reported on monthly at the quality assurance meeting until ongoing compliance is assured.</p>	

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	<p>Based on observation and interview, the facility failed to properly maintain 11 of 11 unattended trash and soiled linen collection receptacles with a capacity of more than 32 gallons within a 64 square foot area. This deficient practice could affect up to 40 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 between at 10:00 a.m., and 12:30 p.m., the following areas contained soiled linen and/or trash receptacles totaling more than 32 gallons in a 64 square foot area:</p> <ul style="list-style-type: none"> a. in bathing room "one" there were two receptacles b. in bathing room "two" there were two receptacles c. in bathing room "five" there were two receptacles d. in the restroom by room 36 there were three receptacles e. in the beauty shop there were two receptacles <p>All rooms were not protected as a hazardous area and each room was only occupied for a few hours a day. Based on interview at the time of observation, the Maintenance Supervisor stated the receptacles were stored in the aforementioned rooms but, the capacity</p>	K 0075	<p>1. No residents were affected. 2. All residents have the potential to be affected. 3. All staff have been reeducated on this deficiency to ensure compliance of not leaving collection receptacles unattended. 4. A quality assurance audit has been implemented to ensure compliance. The audit will be completed weekly and reported on monthly during the quality assurance meeting to ensure ongoing compliance.</p>	12/04/2015

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	of each collection receptacle did not total more than 32 gallons. The Maintenance Supervisor did acknowledge that the receptacles in each room where less than eight feet apart and together the receptacles totaled more than 32 gallons. 3.1-19(b)				