

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 10/28/2013
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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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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/28/13</p> <p>Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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</p>	K010000	Please accept this plan of correction as our allegation of compliance. Pilgrim Manor is requesting a paper compliance for this Life Safety Code inspection. If you have any questions or need more information, please contact: Lori Smith, Administrator, Pilgrim Manor, 574-936-9943. Thank you.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>rooms. The facility has a capacity of 71 and had a census of 53 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached buildings which are a maintenance building, a freezer and the laundry for the facility.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/29/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010014 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on record review, observation and interview; the facility failed to ensure materials used as an interior finish for 5 of 5 corridors had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p>	K010014	<p>K014 1. No residents were found to be affected by this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. The Vestibules at each of the four facility exits have been painted with a Class A flame spread rating paint and the dining room has been varnished with a Class B flame spread rating varnish. 3. The four exits that have wood paneling on each wall has been painted with a Class A flame spread rating paint called Harmony (See Exhibit 1). The dining with wood paneling from the floor to three feet high has been varnished with Class B flame spread rating varnish (See Exhibit 2). 4. Documentation in regards to the paint and varnish will be filed with all of the flame retardant information. This is reviewed each year when the Life Safety Code inspection is completed.</p>	11/08/2013	

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	<p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>This deficient practice could affect all residents, staff or visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:20 p.m. to 4:30 p.m. on 10/28/13, the vestibule at each of the four facility exits had wood paneling installed on each wall from the floor to the ceiling. In addition, the Dining Room had wood paneling installed on each wall from the floor to three feet high on the wall. The Dining Room is open to the corridor.</p> <p>Based on record review with the Administrator and the Maintenance Director from 10:55 a.m. to 12:45 p.m. on 10/28/13, the flame spread rating of wood paneling installed in the vestibule at each of the four building exits and in the Dining Room was not available for review. Based on interview at the time of record review and of the observations, the Administrator and the Maintenance Director acknowledged documentation of the flame spread rating of the wood</p>			

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	<p>paneling was not available for review nor was any documentation available for review to demonstrate the wood paneling had been treated with a flame retardant material.</p> <p>3.1-19(b)</p>			

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K010046 SS=C	<p>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.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 7 of 7 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. 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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Pilgrim Manor "Monthly Maintenance Schedule - 2013" and "Maintenance Schedule - Weekly 2013" battery powered emergency light testing documentation with the Administrator and the Maintenance Director during record review from 10:55 a.m. to 12:45 p.m. on 10/28/13, the</p>	K010046	<p>K046 1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. On 11-6-13 a 30 second test was completed on all 7 battery powered lights. No problems were noted. On 11-7-13 a 90 minute test was completed on all 7 battery powered lights. No problems were noted. Testing was documented on the "Battery-operated Emergency Lights - Test Log for 2013" (See Exhibit 3) 4. At the monthly QA meeting the documentation for the battery powered lights will be reviewed to ensure that the 30 minute monthly tests were completed and that the annual has been completed every 12 months, (See Exhibit 4). The QA committee consists of 13 Department Heads: Administrator, Business Office Manager, Social Service Director, MDS Coordinator, In-Service Director, Director of Nursing, Activity Director, East & West Unit Manager, Environmental Director, Medical Records, Maintenance Director and Dietary Manager.</p>	11/07/2013			

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	<p>following was noted:</p> <p>a. documentation of an annual ninety minute test for each of seven battery operated emergency lights in the facility within the most recent twelve month period was not available for review.</p> <p>b. functional testing documentation at 30 day intervals for not less than 30 seconds for each of seven battery powered emergency lights for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Director acknowledged monthly and annual testing documentation for each of seven battery operated emergency lights was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:20 p.m. to 4:30 p.m. on 10/28/13, a total of seven battery powered emergency lights were observed in the facility and at the emergency generator location and each light functioned when their respective test button was depressed.</p> <p>3.1-19(b)</p>				

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K010052 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to maintain 3 of 21 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:20 p.m. to 4:30 p.m. on 10/28/13, the following was noted:</p> <p>a. the smoke detector on the ceiling in the corridor outside Room 20 was located two inches from an air return vent. b. the smoke detector on the ceiling in the corridor outside Room 33 was located one foot from an air return vent. c. the smoke detector on the ceiling in the</p>	K010052	<p>K052 1. No residents were affected by this alleged deficient practice. 2. All residents had the potential to be affected by this alleged deficient practice. 3.a. The smoke detector outside of Room 20 has been moved from the air return vent by at least 36". (See Exhibit 5) b. The smoke detector outside of Room 33 has been moved from the air return vent by at least 36". (See Exhibit 6) c. The smoke detector on the ceiling in the Water Softener Room now has a deflector in place between the air supply vents and the smoke detector. (See Exhibit 7) 4. The smoke detectors will be checked and monitored on a monthly basis. (See Exhibit 8). Each month the documentation for monitoring the smoke detectors will be reviewed in the Monthly QA Meeting (See Exhibit 4). The QA Committee consists of 13 Department Heads: Administrator, Business Office Manager, Social Service Director, In-Service Director, MDS Coordinator, East and West Unit Managers, Director of Nursing, Medical Records, Activity Director, Dietary</p>	11/05/2013			

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	Water Softener Room was located one foot from each of two air supply vents. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detector locations were each installed less than three feet from an air return or supply vent. 3.1-19(b)		Manager, Environmental Director and Maintenance Director.		

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 34 of 34 resident sleeping rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:20 p.m. to 4:30 p.m. on 10/28/13, all resident sleeping rooms in the east and west smoke compartments were using the egress corridor as a return air system. Each resident sleeping room in the east and west smoke compartments</p>	K010067	K067 A waiver has been requested (See Exhibit 9)	11/08/2013			

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	<p>utilize radiant heat for room heating. Roof mounted air conditioning units supply air conditioning to each of the aforementioned resident sleeping rooms. The return for the air conditioning system is not located in each resident sleeping room but in the corridor of the east and west smoke compartments. Based on interview at the time of the observations and with the Administrator during the exit conference at 4:40 p.m., the Maintenance Director and the Administrator stated the facility uses the egress corridor as a portion of the return air system and acknowledged all resident sleeping rooms were using the egress corridor as a return air system for air conditioning systems serving the east and west smoke compartments.</p> <p>3.1-19(b)</p>			