

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155704	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/30/2014
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NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182
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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: 06/30/14</p> <p>Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Waldron Health and Rehab 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 one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in</p>	K010000	<p>This plan of correction is the facility's Credible Allegation of Compliance.</p> <p>Preparation and/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 in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.</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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K010018 SS=E	<p>all resident sleeping rooms. The facility has a capacity of 79 and had a census of 52 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except a detached wooden garage and wooden shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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>						

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K010130 SS=E	<p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 40 resident room corridor doors latched into the door frame and would resist the passage of smoke. This deficient practice could affects 2 residents who reside in room 26 as well as other residents in the same smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 06/30/14 at 3:40 p.m., resident room 26 door failed to latch into the door frame and had a two inch gap with the door closed. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/30/14 at 4:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC</p>	K010018	K 018 Currently one resident now occupies room #26 with the potential to be affected by this finding. All resident doors were inspected during the 6/30/2014 LSC survey and no other residents were found to be affected by this finding as the resident doors were found to latch adequately to restrict the passage of smoke. On 7/1/2014, the maintenance department made adjustments to the door for room #26 to ensure it closes fully into the door frame with no excessive gaps. The door for room #26 after the adjustment will latch securely to resist the passage of smoke. During the weekly Quality Assurance/preventive maintenance rounds (Attachment A) and routinely scheduled fire and safety rounds conducted by the maintenance department and or designee, the resident doors are closed and inspected for proper latching. The weekly inspection will ensure the resident door(s) remain correctly adjusted, serving to resist the passage of smoke.	07/10/2014			
		K010130	K 130 This finding was not found to have a direct affect on any specific resident. The finding had the potential to have affected all residents of the	07/09/2014			

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	<p>4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 39 residents who use the main dining room which is located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 06/30/14 at 2:45 p.m. with the administrator and maintenance supervisor, there wasn't an inspection tag attached on the rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview at the time of observation, the maintenance supervisor verified there was no documentation of an annual inspection or test since the installation to check for proper operation and full</p>		<p>facility due to the location of the rolling door that separates the kitchen from the main dining room. On 7/3/2014, the rolling door/shutter was inspected and serviced by SafeCare (Attachment B). At the time of inspection the rolling door was tension was adjusted, and the Maintenance manager who recently started employment was provided training by SafeCare on the rolling door which included instruction for resetting the door/shutter. During the 7/3/2014 inspection the rolling door was found to be working properly and in accordance with manufacturer instruction. A new stop pin was installed as a preventive maintenance action and a inspection tag was placed for verification of the inspection. The Maintenance manager has added the annual rolling door inspection to the vendor (SafeCare) inspection and service schedule. Maintenance will additionally inspect and monitor functionality of the rolling door in the departmental quality assurance/preventive maintenance program scheduled rounds.</p>				

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K010144 SS=F	<p>closure of the vertical rolling fire door. This was acknowledged by the administrator at the exit conference on 06/30/14 at 4:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p>	K010144	K 144 This finding was not found to have affected any specific resident of the facility. A review of the finding did not reveal other residents with a potential to be affected. It is noted on the LSC survey dated 6/30/2014 that the facility failed to indicate on the monthly generator load test report, the "percent of load or exhaust gas temperature". The attached copy (Attachment C) showing the monthly load test report which was presented to the LSC Surveyor, did in fact indicate the "% of load" highlighted on attachment C. In accordance with the NFPA Standard, 2013 Edition (Attachment D), the generator "shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the	07/09/2014

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	<p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Monthly Load Test Log with the administrator and maintenance supervisor on 06/30/14 at 1:00 p.m., the monthly load test reports over the past year failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load test reports indicated amperage with no indication of the nameplate rating of the emergency generator nor the required calculations to convert amperage into a percent of load. The lack of a percent of load listed on the monthly load test reports was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 06/30/14 at 4:40 p.m.</p> <p>3.1-19(b)</p>		<p>minimum exhaust gas temperatures as recommended by the manufacturer (2) Under the operating temperature conditions and at no less than 30 percent of the EPS standby nameplate KW rating". Attachment C reflects that method (2) was met. As indicated on the monthly load test report, the percent of load for each month recorded over the past 20 months exceeded 30% of load which made the recording of exhaust temperature not necessary according to NFPA Standard. The facility additionally consulted with the generator service contractor to verify the NFPA Standard was met using the completed load test report (Attachment C) provided to the LSC Survey at the time of inspection. The maintenance manager will continue to complete at least monthly the load test report. Readings and or findings will be reviewed as an ongoing quality assurance measure for proper generator functioning. Load test readings that are not within the normal generator operating threshold will be addressed through in house maintenance service and or a generator service contractor to ensure optimum operation and generator function.</p>		

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K010147 SS=E	<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 2 of 38 wet location resident care areas were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects staff who use the central nourishment pantry and central soiled linen room.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K010147	<p>K 147No resident was found to be affected by this finding. The nourishment pantry and soiled utility room identified in this finding are not resident accessible areas, therefore no resident is considered to have potential to be affected by this finding. The maintenance manager on 7/1/2014 replaced the electric receptacle in the nourishment pantry and soiled utility room referenced in this finding with GFCI protection electric receptacles (Attachment E). The maintenance manager completed a comprehensive inspection of the facility to identify any area(s) in which a electrical receptacle was located within three feet of a water source. Based on the department quality assurance/preventive maintenance inspection, two electrical receptacles were identified and replaced with GFCI protection electric receptacles (Attachment F). The maintenance manager and or designee will continue to monitor through routine facility quality assurance rounds, preventive maintenance rounds, and inspections for</p>	07/09/2014

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K020000	<p>administrator and maintenance supervisor on 06/30/14 during a tour of the central nurses' station from 2:50 p.m. to 3:50 p.m., the nourishment pantry and soiled linen room each had an electric receptacle on the wall within three feet of the handwash sinks with no ground fault circuit interrupters on the electric outlets. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breakers for the electric outlets were not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/30/14 at 4:20 p.m.</p> <p>3.1-19(b)</p> <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: 06/30/14</p> <p>Facility Number: 000423</p> <p>Provider Number: 155704</p>	K020000	<p>potential safety concerns. The facility has no current renovation plan scheduled that would impact additional electrical receptacles having a proximity to a water source.</p> <p>This plan of correction is the facility's Credible Allegation of Compliance.</p> <p>Preparation and/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 in the statement of deficiencies. The</p>				

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	<p>AIM Number: 100290450</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Waldron Health and Rehab 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 2011 Rehabilitation room addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story Rehabilitation Room addition was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 79 and had a census of 52 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except a detached wooden garage and wooden shed.</p>		<p>plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.</p>				

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K020144 SS=F	<p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum</p>	K020144	K 144 This finding was not found to have affected any specific resident of the facility. A review of the finding did not reveal other residents with a potential to be affected. It is noted on the LSC survey dated 6/30/2014 that the facility failed to indicate on the monthly generator load test report, the "percent of load or exhaust gas temperature". The attached copy (Attachment C) showing the monthly load test report which was presented to the LSC Surveyor, did in fact indicate the "% of load" highlighted on attachment C. In accordance with the NFPA Standard, 2013 Edition (Attachment D), the generator "shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under the operating temperature conditions	07/09/2014

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	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents in the facility using the rehabilitation addition.</p> <p>Findings include:</p> <p>Based on a review of the Generator Monthly Load Test Log with the administrator and maintenance supervisor on 06/30/14 at 1:00 p.m., the monthly load test reports over the past year failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load test reports indicated amperage with no indication of the nameplate rating of the emergency generator nor the required calculations to convert amperage into a percent of load. The lack of a percent of load listed on the monthly load test reports was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 06/30/14 at 4:40 p.m.</p> <p>3.1-19(b)</p>		<p>and at no less than 30 percent of the EPS standby nameplate KW rating". Attachment C reflects that method (2) was met. As indicated on the monthly load test report, the percent of load for each month recorded over the past 20 months exceeded 30% of load which made the recording of exhaust temperature not necessary according to NFPA Standard. The facility additionally consulted with the generator service contractor to verify the NFPA Standard was met using the completed load test report (Attachment C) provided to the LSC Survey at the time of inspection. The maintenance manager will continue to complete at least monthly the load test report. Readings and or findings will be reviewed as an ongoing quality assurance measure for proper generator functioning. Load test readings that are not within the normal generator operating threshold will be addressed through in house maintenance service and or a generator service contractor to ensure optimum operation and generator function.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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