

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/02/15</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage Park 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, areas open to the corridors and hard wired smoke detectors in the</p>	K 000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after	
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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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K 046 SS=F Bldg. 01	<p>resident rooms on the 200 hall. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 180 and had a census of 154 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one shed used for the maintenance office and general storage and an additional shed used for maintenance storage.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/04/15.</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 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation, record review and interview; the facility failed to ensure 9 of 9 emergency light fixtures of at least 1½ hour duration were tested annually in</p>	K 046	It is the practice of this provider to ensure emergency light fixtures of at least 1 and 1/2 hour duration are tested annually. What corrective actions(s) will be	03/10/2015

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	<p>accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall 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 occupants.</p> <p>Findings include:</p> <p>Based on observation and record review with the Maintenance Supervisor on 03/02/15 at 9:25 a.m., the Battery Operated Emergency Lights-Test Log for 2014 and 2015 did not show a 90 minute annual test. Based on an interview during the review, the Maintenance Supervisor confirmed there was no 90 minute test recorded.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the deficient practice: No residents were found to have been affected. How will you identify other residents having the potential to be affected by the same deficient practice: Residents living in the facility have the potential to be affected by the deficient practice. What changes will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The emergency light fixtures were tested March 2, 2015 with no concerns identified. The system will be tested again in June 2015 and annually in June thereafter. The annual testing is now scheduled in the Preventative Maintenance Log for the month of June. The Maintenance Director/Designee is responsible for oversight. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI tool titled "Annual 90-Min Emergency Light Fixture Testing" audit will be completed annually in June. Results will be presented to the governing CQI committee overseen by the Executive Director. If threshold of 100% is not met- an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>		

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K 062 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of "Report of Inspection" sprinkler inspection documentation from P.I.P.E. with Maintenance Supervisor on 03/02/15 at 10:00 a.m., the facility lacked documentation of a sprinkler inspection where the waterflow alarms were tested for the fourth quarter of 2014. Based on an interview at the time of record review, the Maintenance Supervisor was aware the sprinkler inspection was missing for the fourth quarter of 2015 and stated there was no fourth quarter inspection</p>	K 062	<p>It is the practice of this facility to ensure sprinkler waterflow alarm devices are tested quarterly, sprinkler heads are free of paint, corrosion, damage, load, are oriented properly and sprinkler spray patterns are unobstructed. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents living within the facility have the potential to be affected by the alleged deficient practice. The sprinkler waterflow alarm was tested March 3, 2015 identified concerns were corrected. The waterflow testing is now scheduled in the Preventative Maintenance Log quarterly. The sprinkler heads identified in the 2567 have been replaced. The maintenance department completed a visual audit of sprinkler heads throughout the facility. No</p>	03/10/2015

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	<p>because the facility was switching to a different contractor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 5 of over 300 sprinklers in the facility which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all residents using the main dining room, 24 residents in the 400 hall, and 11 residents in the 500 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor on 03/02/15 between 10:40 a.m. and 1:00 p.m., the following automatic sprinklers had paint on the fusible link and/or the deflector.</p> <p>a. 1 of 2 sprinkler heads in the 400 hall shower room</p> <p>b. 1 of 2 sprinkler heads in room 402</p> <p>c. 2 of 2 sprinkler heads in room 502</p>		<p>additional spinkler heads were found to be affected. The computer equipment was remounted to a distance of 12-inches below the sprinkler head to ensure no obstruction of the spray pattern. The maintenance department completed a visual audit of mounted items throughout the facility. No additional items were found to be mounted obstructing sprinkler spray patterns. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The waterflow testing is now scheduled in the Preventative Maintenance Log quarterly. The maintenance department will conduct scheduled rounds to visually check sprinkler heads throughout the facility to ensure they are free of paint, corrosion, damage, load and properly oriented. The maintenance department will conduct scheduled rounds to visually check that no items are mounted in such a way to obstruct the spray pattern. The Maintenance Director/Designee is responsible for oversight. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled, "Quarterly Waterflow Testing" will be completed quarterly. A CQI Monitoring Tool titled, "Sprinkler Head Audit" will be completed</p>	

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	<p>d. 1 of 7 sprinkler heads in the main dining-room</p> <p>Based on interview at the time of observation, the painted sprinkler heads were acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinklers in the 600-700 hall nurse's med-room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 30 residents in the 600 and 700 halls.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Supervisor on 03/02/15 at 10:30 a.m.,</p>		<p>weekly x 4, Monthly x 6 and quarterly thereafter. Results will be presented to the governing CQI Committee overseen by the Executive Director. If threshold of 95% is not met- an action plan will be developed.</p> <p>Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>there was computer equipment mounted on the wall less than four inches from and directly below a sprinkler head causing obstruction of the spray pattern. Based on interview, the Maintenance Supervisor acknowledged the obstructed sprinkler at the time of observation.</p> <p>3.1-19(b)</p>			