

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2013
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NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
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K010000	<p>A Life Safety 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: 10/09/13</p> <p>Facility Number: 000483 Provider Number: 15E657 AIM Number: 100273470</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Silver Memories Health Care was found not in compliance with Requirements for Participation in 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 two story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detection in all resident sleeping rooms. The facility</p>	K010000		

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>has a capacity of 29 and had a census of 17 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the nurses station air handler room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 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 2 of 30 corridor doors were constructed to resist the passage of smoke. This deficient practice could affect 2 residents who reside in resident room 8 and 10 residents who use the main dining room, located across the corridor from the kitchen food storage room.</p> <p>Findings include:</p> <p>Based on observations on 10/09/13 during a tour of the facility from 11:45 a.m. to 2:50 p.m. with the administrator and maintenance supervisor, the corridor door to resident room 8 and the kitchen food storage room corridor door failed to close and latch into their door frames, leaving</p>	K010018	K 018 NFPA 101 - Life Safety Code Standard On October 10, 2013, the door to the kitchen storage area and the corridor door to room # 8 were adjusted to ensure they closed and latched properly. The hinges to the food storage doors were repaired. All doors in the facility were inspected by the maintenance supervisor to ensure closure. The maintenance supervisor will be responsible to inspect all doors monthly to ensure proper closing. CQI will visually monitor doors during facility tours, no less than quarterly.	11/10/2013	

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	<p>between a three quarter inch to one inch gap. Furthermore, the kitchen food storage room door hinges were separating from the door frame. This was acknowledged by the administrator at the time of observations and at the exit conference on 10/09/13 at 3:10 p.m.</p> <p>3.1-19(b)</p>				

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K010025 SS=F	<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 1 of 1 ceiling smoke barriers and 1 of 2 corridor walls was 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 all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor on 10/09/13 during a tour of the facility from 11:45 a.m. to 2:50 p.m., the following ceiling smoke barriers were not fire stopped:</p> <p>a. The soiled linen room ceiling had a one half inch gap around an electrical conduit penetration.</p> <p>b. The kitchen storage room ceiling had four, six inch square to twelve inch square</p>	K010025			01/07/2014		

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	<p>areas of drywall missing around electrical conduit and sprinkler piping.</p> <p>c. The kitchen food storage room ceiling had four, one inch gaps in the drywall around electrical conduit penetrations.</p> <p>d. The main corridor north wall outside the nurses' station staff bathroom had a twelve inch by two inch area and a six inch by eight inch area of drywall missing near the wall/floor juncture.</p> <p>e. The main office in the East Hall had a three inch by twelve inch area of drywall missing around the air duct penetration and two, one half inch gaps around electrical conduit penetrations.</p> <p>The gaps in the soiled linen room ceiling, the kitchen storage room missing drywall, the kitchen food storage room gaps, the main corridor north wall missing drywall, and the main office missing drywall and ceiling penetrations were verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p> <p>3.1-19(b)</p>		K 025NFPA - Life Safety Code Standard	

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			<p>The following smoke barrier ceilings were repaired or scheduled for repair as follows:</p> <p>A.) On October 20, 2013, fire caulking was applied to the gap in</p>	

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			<p>the soiled utility room around the electrical conduit.</p> <p>B.) The kitchen storage areas missing dry wall areas will be repaired by January 07, 2014</p>	

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			C.) The kitchen storage room one inch gaps were repaired with fire caulk.	

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			D.)Dry wall will be replace in the north wall outside the nurses station/ staff bathroom wall, by	

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			January 7, 2014.	

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			E.) The drywall will be repaired/replaced in the areas noted in this report in the east hall office area, gaps around the electrical conduit, gaps in the soiled utility room, gaps in the kitchen food storage, missing dry wall will be repaired by January 07, 2014.	

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			<p>The maintenance supervisor will be responsible to ensure all areas are repaired to specifications of the NFPA 101 Life Safety code. CQI will monitor repairs and completion is timely.</p>	

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K010027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 10/09/13 at 2:20 p.m. during a test of the fire alarm system with the administrator and maintenance supervisor, the Main Hall smoke barrier door did not close completely, leaving a two inch gap where the door met the door</p>	K010027	K 027 NFPA 101 - Life Safety Code The door frame to the main hall smoke barrier door was adjusted and repaired to allow adequate closure. The maintenance supervisor will be responsible to inspect all doors monthly to ensure proper closing. CQI will visually monitor doors during facility tours, no less than quarterly.	10/10/2013			

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	<p>frame. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 hazardous areas, such as a soiled linen room, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects all residents who use the main dining room, located adjacent to the soiled linen room.</p> <p>Findings include:</p> <p>Based on observation on 10/09/13 at 12:40 p.m. with the administrator and maintenance supervisor, the soiled linen room door self closing device did not allow the door to self close and latch, leaving a one inch with the door in the closed position. This was verified by the administrator and maintenance supervisor at the time of observation and</p>	K010029	K 029 NFPA 101 - Life Safety Code Standard On October 10, 2013, the self closing device on the soiled utility room door was adjusted and the door knob changed to ensure adequate closure of the soiled utility door. The maintenance supervisor will be responsible to inspect all doors monthly to ensure proper closing. CQI will visually monitor doors during facility tours, no less than quarterly.	10/10/2013			

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	acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m. 3.1-19(b)			

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K010056 SS=F	<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 ensure 1 of 30 rooms were sprinklered. This deficient practice affects all residents who use the main dining room, located across the corridor from the air handler room.</p> <p>Findings include:</p> <p>Based on observation on 10/09/13 at 2:15 p.m. with the administrator and maintenance supervisor, the air handler room located near the Main Hall nurses' station was not provided with sprinkler coverage. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p>	K010056	<p>On December 5, 2013, Koorsen's Fire Protection installed a sprinkler head in the air handler room. The maintenance supervisor will monitor that this requirement is maintained. CQI will monitor Koorsen's Fire Protection quarterly reports, quarterly.</p>	12/05/2013			

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K010061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 Post Indicator Valves and 1 of 1 low air pressure switch alarms were provided with an electrical alarm which alarmed when the valve was closed or the air pressure caused the switch to alarm. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the Koorsen Fire and Security Inc. Quarterly Sprinkler System Inspection Report dated 04/03/13 with the administrator on 10/09/13 at 11:45 a.m., the report indicated in the remarks section the low air pressure alarm and post indicator valves do not report to the fire alarm system control panel. Based on an interview with the administrator on 10/09/13 at 12:10 p.m., an estimate was</p>	K010061	Koorsen's Fire Protection replaced the low pressure air valve and provided documentation of the replacement of the post indicator valve gauge. The automatic sprinkler system local alarm will be inspected by Koorsen's Fire and Safety during their quarterly inspections. The maintenance supervisor will monitor that this requirement is maintained. CQI will monitor Koorsen's Fire Protection quarterly reports, quarterly.	10/11/2013			

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	<p>acquired for the electrical connection from the post indicator valve and the low pressure alarm to the fire alarm system panel, but the repair work has not been completed. The lack of an electrical alarm from the Post Indicator Valve and Low Pressure Alarm for the sprinkler system to the fire alarm system panel was acknowledged by the administrator at the exit conference on 10/09/13 at 2:50 p.m.</p> <p>3.1-19(b)</p>				

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K010062 SS=F	<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 1 of 1 dry pipe automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system Quarterly Sprinkler System Inspection Reports and interview with the administrator on 10/09/13 at 11:30 a.m., none of the Quarterly Sprinkler System Inspection Reports dating from 10/01/12</p>	K010062	<p>K 062 NFPA 101 - Life Safety Code</p> <p>1.) An internal inspection of the automatic sprinkler system was completed on December 5, 2013 by Koorsen's Fire Protection. CQI will be responsible to review quarterly sprinkler inspection reports, no less than quarterly.</p> <p>2.) Koorsen's Fire Protection replaced the low air valve gauge and provided documentation for the replacement of the other valve gauges.</p> <p>3.) The facility has ordered 2 spare side wall mount sprinkler head from Koorsen's Fire Protection.</p>	12/05/2013			

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	<p>to 07/10/13 indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the administrator indicated she did not have a record of an internal inspection of the dry pipe sprinkler system available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 3 of 3 sprinkler system gauges were replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of Quarterly Sprinkler System Inspection Reports on 10/09/13 at 11:40 a.m. with the administrator, there was no record the three sprinkler system gauges had been replaced over the past five years. Based on observation of the sprinkler riser on 10/09/13 at 1:45 p.m. with the administrator and maintenance supervisor, there were three gauges on the</p>		<p>The administrator will monitor and be responsible to ensure completion of the internal inspection is conducted on or before December 5, 2013. CQI will be responsible to review quarterly sprinkler inspection reports, no less than quarterly.</p>				

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	<p>sprinkler riser with no date of manufacturer on any gauge. The lack of the three sprinkler system gauges being replaced every five years was verified by the administrator and maintenance director at the time of observation of the sprinkler system riser and acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for 1 of 1 automatic sprinkler systems in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p>						

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	<p>Findings include:</p> <p>Based on observation on 10/09/13 at 1:45 p.m. with the administrator and maintenance supervisor, there was one spare sidewall sprinkler in the spare sprinkler cabinet located in the sprinkler riser room across from the administrator office. During a tour of the facility on 10/09/3 from 11:45 a.m. to 2:50 p.m. with the administrator and maintenance supervisor, sidewall mounted sprinklers were observed in the eleven resident sleeping rooms. The lack of two spare sidewall sprinklers in the spare sprinkler cabinet was acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p> <p>3.1-19(b)</p>				

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 11 of 11 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on an interview on 10/09/13 at 11:45 a.m. with administrator, the facility has eleven resident rooms with battery operated smoke detectors located in each of the resident rooms. Furthermore, there was no preventive maintenance program to document monthly testing and annual battery replacement for each battery operated smoke detector. The lack of a written maintenance program to provide monthly testing and annual battery replacement for the eleven resident room battery operated smoke detectors was verified by the administrator at the time of interview and acknowledged by the administrator at the exit conference on 10/09/13 at 3:10 p.m.</p>	K010130	The maintenance supervisor checked all smoke detectors, October 29, 2013. The policy and procedure for maintenance of smoke detectors were reviewed. All smoke detectors will be reviewed monthly with the monthly fire drill. The maintenance supervisor is responsible to ensure smoke detectors are checked monthly. CQI will review monthly maintenance reports, no less than quarterly.	10/29/2013			

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