

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155812	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CONCORD ROAD CRAWFORDSVILLE, IN 47933
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K 0000 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: 01/20/16</p> <p>Facility Number: 013107 Provider Number: 155812 AIM Number: 201279670</p> <p>At this Life Safety Code survey, Wellbrooke of Crawfordsville 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This two 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, hard wired smoked detectors in all resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 70 and had a census of 61 at the time of this survey.</p>	K 0000		
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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 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered and all areas which provide facility services was sprinklered.</p> <p>Quality Review completed on 01/29/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 double door sets separating the kitchen from the emergency exit corridor would resist the passage of smoke. This deficient practice could affect 10 residents in the adjacent corridor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/20/16 at 1:30 p.m. with the Maintenance Supervisor, the double door set protecting the Service corridor from the kitchen had a 1/2 inch gap where the kitchen doors meet in the middle. Based on interview on concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the aforementioned set of corridor double doors would not resist</p>	K 0018	<p>K 018</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The double door set protecting the Service Corridor from the Kitchen was adjusted in order to have less than ¼" gap where the doors meet in the middle so as to resist the passage of smoke.</p> <p>How other residents having the potential to be affected by the</p>	02/19/2016

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	the passage of smoke. 3.1-19(b)		<p>same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. All doors protecting corridor openings checked. No other doors found to be in violation of life safety code standard.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly door checks will be completed by Director of Plant Operations (DPO) or designee on an ongoing basis to ensure exit corridors are resistant to passage of smoke.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of the monthly door audit will be brought to the monthly</p>	

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 smoke compartments were constructed to maintain the one hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke</p>	K 0025	<p>Quality Assurance (QA) meeting x 3 months, then quarterly unless otherwise determined by the Interdisciplinary Team (IDT) at the QA meeting.</p> <p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p> <p>K 025</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>	02/19/2016

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	<p>barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 10 residents on 100 hall south and 10 residents on 200 hall west as well as visitors and staff if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observations on 01/20/16 during the tour between 2:00 p.m. to 3:00 p.m. with the Maintenance Supervisor, the Electrical rooms on 100 hall south and 200 hall west had more than twenty five wires penetrating the ceiling in each room and the penetration was sealed with an orange foam which lacked documentation of being tested as a Through Penetration Fire Stop System. Based on interview on 01/20/16 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned penetrations in the ceiling smoke barrier had not been firestopped with an approved material..</p> <p>3.1-19(b)</p>		<p>Ceiling penetrations in the Electrical rooms on 100 Hall South and 200 Hall West have been sealed with a Through Penetration Fire Stop System caulk.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. All areas checked for penetrations of smoke compartments and for penetrations sealed with material not meeting Through Penetration Fire Stop System code standards. No other areas or materials found to be in violation of life safety code standard.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>All new construction or renovation projects will be reviewed for smoke compartment penetrations which</p>				

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K 0038	NFPA 101		<p>will be sealed with a Through Penetration Fire Stop System caulk. As a preventative maintenance (PM) measure, quarterly checks will be completed to ensure fire retardant barriers remain in place x 1 year.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place.</p> <p>DPO will provide the quarterly checks to ensure the fire retardant barriers remain in place x 1 year. Corporate plant operations support will provide direction at the end of the 1-year review to determine if further monitoring will be required. The quarterly checks will be brought to the monthly QA meeting unless otherwise determined by the IDT at the QA meeting.</p> <p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p>	

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks met all conditions of LSC 7.2.1.6.1 so it would be readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release</p>	K 0038	<p>K 038</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The maglock on the exit door leading out of the 100 Hall West was adjusted. Initiation of the exit door release process activates the door alarm to sound and the maglock to release per life safety code standard.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. All exit doors checked. All exit doors have signage in letters not less than 1 inch high and at least 1/8 inch in stroke width that reads "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15</p>	02/19/2016			

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	<p>the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 01/20/16 at 2:35 p.m. with the Maintenance Supervisor the exit door leading out of the 100 hall west was provided with a delayed egress lock and a sign stating the door could be opened in 30 seconds by</p>		<p>SECONDS." All exit doors tested, pressure applied to the releasing device sounds the door alarm and the maglock releases per life safety code standard.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly checks will be completed by Director of Plant Operations (DPO) or designee of the exit door alarms and maglock releases.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of the monthly exit door checks will be brought to the monthly Quality Assurance (QA) meeting x 3 months, then quarterly unless otherwise determined by the Interdisciplinary Team (IDT) at the QA meeting.</p>		

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K 0048 SS=F Bldg. 01	<p>pushing on the door, but when the door was tested and pressure applied the alarm did not sound and the maglock did not release. Furthermore, all exits with delayed egress had a sign stating the door could be opened in 30 seconds instead of 15 seconds. The other doors when tested at the time of observation released in 15 seconds. Based on interview concurrent with the observations, it was acknowledged by the Maintenance Supervisor the aforementioned exit door with a delayed egress lock did not respond as the sign indicated it would release in 30 seconds and the signs were incorrect for all delayed egress exit doors in that they stated the doors would release in 30 seconds instead of 15 seconds..</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to ensure 1 of 1 Fire Safety plans was available for review. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p>	K 0048	<p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p> <p>K 048</p> <p>What corrective action(s) will be accomplished for those residents</p>	02/19/2016			

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	<p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a record review of the facility's written fire disaster plan on 01/20/16 at 3:45 p.m. with the Maintenance Supervisor the fire disaster plan was not available for review. Based on an interview on concurrent with review it was acknowledged by the Maintenance Supervisor a written fire safety plan for the facility was not available for staff to review in the event of a fire emergency.</p> <p>3.1-19(b)</p>		<p>found to have been affected by the deficient practice.</p> <p>Emergency and Disaster Preparedness Manual, including the facility's Fire Disaster Plan was written and placed at each Nurse Station, Reception Desk, Director of Plant Operations office, Director of Health Services office and Executive Director office.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. Emergency and Disaster Preparedness Manual, including the facility's Fire Disaster Plan was written and placed at each Nurse Station, Reception Desk, Director of Plant Operations office, Director of Health Services office and Executive Director office.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>	

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			<p>In-service education provided to staff regarding location and content of the Emergency and Disaster Preparedness Manual that includes the facility's Fire Disaster Plan. Monthly checks will be completed by Director of Plant Operations (DPO) or designee of the presence of the Manual in the designated locations.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place.</p> <p>Results of the monthly Manual checks will be brought to the monthly Quality Assurance (QA) meeting x 3 months, then quarterly unless otherwise determined by the Interdisciplinary Team (IDT) at the QA meeting.</p> <p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 10 residents on 100 hall south as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 01/20/16 at 2:26 p.m. with the Maintenance Supervisor, the oxygen storage room on 100 hall south used to store and transfer oxygen was provided with an electrically powered vent but it was not working.</p>	K 0143	<p>K 143</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The electrically powered vent in the oxygen storage room on 100 Hall South, used to store and transfer oxygen, was repaired and is now working.</p>	02/19/2016	

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	<p>Based on interview on 01/20/16 at 2:30 p.m. it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and was unaware the vent was not working.</p> <p>3.1-19(b)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. This is the only oxygen storage room in the facility.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly checks will be completed by Director of Plant Operations (DPO) or designee of the electrically powered vent in the oxygen storage room.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of the monthly vent check will be brought to the monthly Quality Assurance (QA) meeting x 3</p>	

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K 0147 SS=E Bldg. 01	<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 1 of 1 extension cords was not used to power electrical equipment. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 9 residents on 100 hall east as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/20/16 at 1:04 p.m. an extension cord was used to provide power to a copy machine located</p>	K 0147	<p>months, then quarterly unless otherwise determined by the Interdisciplinary Team (IDT) at the QA meeting.</p> <p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p> <p>K 143</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The electrically powered vent in the oxygen storage room on 100 Hall South, used to store and transfer oxygen, was repaired and is now working.</p> <p>How other residents having the</p>	02/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155812	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CONCORD ROAD CRAWFORDSVILLE, IN 47933
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	<p>in the Director of Health Services on 100 hall east. Based on interview on 01/20/16 concurrent with the observation it was acknowledged by the Maintenance Supervisor, an extension cord was used to power the aforementioned electrical appliance and further stated extension cords were not allowed to be used.</p> <p>3.1-19(b)</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents have potential to be affected. This is the only oxygen storage room in the facility.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly checks will be completed by Director of Plant Operations (DPO) or designee of the electrically powered vent in the oxygen storage room.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of the monthly vent check will be brought to the monthly Quality Assurance (QA) meeting x 3 months, then quarterly unless</p>	

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			<p>otherwise determined by the Interdisciplinary Team (IDT) at the QA meeting.</p> <p>By what date the systemic changes will be completed.</p> <p>February 19, 2016.</p>		