

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155524	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2016
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NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441
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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: 09/29/16</p> <p>Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000</p> <p>At this Life Safety Code survey, Health Center At Glenburn Home 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 hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms in the 400 north hall, 500 north hall, 600 hall, and 700 hall, and 700 rehabilitation suite rooms, plus battery operated smoke</p>	K 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective October 17, 2016 to the state findings of the Life Safety Code Recertification Survey conducted on 09-29-16.</p>	
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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 0025 SS=E Bldg. 01	<p>detectors in the 300 south hall, 400 south hall, 500 south hall and all Special Care Unit resident sleeping rooms, including the 100 and 200 halls. The facility has a capacity of 137 and had a census of 130 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except an attached structure used as a maintenance shop and storage room separated from the facility by a two hour fire wall, and one detached garage used for facility storage.</p> <p>Quality Review completed on 10/07/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials</p>	K 0025	<i>The corrective action taken for those residents found to be affected by the deficient practice is that the two foot by two foot open metal damper with six wires running through it on the wall between the 400 and 600 halls has been sealed. The facility contracted Safe Care to move the nurse call wires in that area. The Maintenance staff</i>	10/17/2016

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	<p>such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke 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 up to 30 residents, staff and visitors in portions of the 400 and 600 halls.</p> <p>Findings include:</p> <p>Based on observation on 09/29/16 at 2:40 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall in the attic between the 400 and 600 halls (near room 416) had a two foot by two foot open metal damper with six wires running through it which would not resist the passage of smoke in the event of a fire. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the open damper in the smoke barrier wall between the 400 and 600 halls.</p> <p>3.1-19(b)</p>		<p>then removed the phone and computer wires and ran them under the smoked damper door and sealed around the wires with fire rated caulking. The damper door was seal with 5/8 inch drywall and all areas around the drywall were sealed with fire rated caulking.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all fire walls was completed and no other breeches in the smoke barrier walls were found.</i></p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the maintenance department will check all smoke barrier walls as part of their preventative maintenance program to ensure that there are no breeches in the smoke barrier walls.</i></p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by a Quality Assurance Tool has been developed and implemented to ensure that all smoke barrier walls are protected to maintain the smoke resistance of the smoke barrier. This tool will be completed by the Director of Maintenance and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p>		

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/29/16 at 10:15 a.m. with the Maintenance Supervisor present, the following was noted:</p> <p>a. Three of four, second shift (evening) fire drills were performed between 3:10 p.m. and 3:55 p.m.</p> <p>c. Three of four, third shift (night) fire drills were performed between 6:00 a.m.</p>	K 0050	<p>F 050</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice is that fire drills are now being conducted at least two hours apart from the prior fire drill to ensure that the drills are being conducted at varied times each quarter.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that fire drills are now being conducted at least two hours apart from the prior fire drill to ensure that the drills are being conducted at varied times each quarter.</i></p>	10/17/2016

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	<p>and 6:40 a.m.</p> <p>During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the second and third shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p>		<p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all employees of the maintenance department on the scheduling of fire drills to ensure their knowledge of the importance of conducting fire drills at different times each quarter.</i></p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed in implemented to monitor the timing of fire drills to ensure that they are conducted at different times on each shift each quarter. This tool will be completed by the Administrator and/or her designee monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</i></p>	