STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155385	A. BUILDING -- B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAMELOT CARE CENTER	1555 COMMERCE ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/27/24 Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810 At this Emergency Preparedness survey, Camelot Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 91 certified beds. At the time of the survey, the census was 83. Quality Review completed on 08/29/24	E 0000	=”” p=””>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. =”” p=””> =”” p=””>Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the provider’s allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly. =”” p=””> =”” span=””> =”” p=””> =”” p=””> =”” p=””>	
K 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha D. Biddle	BSN, RN, HFA/Administrator	09/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155385	A. BUILDING 02 B. WING	08/27/2024

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Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/27/24 Facility Number: 000466 Provider Number: 155385 AIM Number: 100289810 At this Life Safety Code survey, Camelot Care 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility is protected by a Type I EES diesel powered generator which supports the vent unit in rooms 33 through 40. The facility has a capacity of 91 and had a census of 83 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled except for an aluminum shed used for storage which was not sprinklered. Quality Review completed on 08/29/24	K 0000	=" " p=" ">Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. =" " p=" "> =" " p=" ">Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the provider's allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly. =" " p=" "> =" " span=" "> =" " p=" "> =" " p=" "> =" " p=" ">	

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	155385	A. BUILDING 02 B. WING	08/27/2024

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K 0291 SS=E Bldg. 02	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect as many as 8 residents, 6 staff and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Director on 08/27/24, the battery-operated emergency light in the Mechanical / Sprinkler room door location failed to function when its respective test button was pushed five times. Based on interview at the time of the observation, the Maintenance Director stated battery operated lights in the facility are tested monthly but acknowledged the aforementioned battery-operated emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0291	K291 Emergency Lighting All Residents have the potential to be affected by this deficient practice. No Residents were affected by this deficient practice. The emergency lighting policy and procedure has been reviewed with no changes made. The emergency light located outside of the mechanical/sprinkler room was replaced on 08/28/2024 by the Maintenance Director. The Maintenance Director after installation tested device and the device illuminated. (See attachment A1, A2) The Maintenance Director or designee will complete monthly emergency light testing in conjunction with the preventative maintenance program and submit these results to the Quality Assurance Committee for review. Any defective light identified during his monthly inspection will be replaced immediately. (See attachment B) ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	08/28/2024

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K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor door to 2 of over 6 hazardous areas, such as a House Keeping/Bio-hazard room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 18 residents, 4 staff and 2 visitors within the facility. Findings include: Based on observations made on 08/27/24 during a tour of the facility between 11:45 a.m. to 2:10 p.m. with the Maintenance Director, the following was noted: a) The "Brief Room", a room approximately 150 square feet in size, had numerous bags of plastic wrapped diapers stored there creating a hazardous area due to the quanity of combustible materials. The corridor door to this room was not provided with a self-closing device. b) The Business office had a large quanity of combustiible material due to numerous papers and files, tubs full of files, and banker's boxes of paper files within it. The room measured approximately 120 square feet in size. The corridor door to this office did not have a self-closing device attached to it. The lack of a self-closing device on each of the aforementioned doors / hazardous areas was acknowledged by the Maintenance Director at the time of each observation who added that he would have the self-closing devices installed on the doors as soon as possible.	K 0321	=" " p=" "> All Residents have the potential to be affected by this deficient practice. No Residents were affected by this deficient practice. The brief room door and Business office door had automatic door closures installed on 09/05/2024 by the Maintenance Director. After installation they were tested and doors latched appropriately into the door frame. (See Attachment C1, C2, C3, C4) The Maintenance Director of designee in conjunction with the preventaitve maintenance program will complete monthly door inspections indefinitely. The Maintenance Director or designee will submit to the monthly Quality Assurance Committee the results of these door inspections. Should any automatic door closure fail to operate or if an area is identified to require an automatic door closure, one will be replaced or installed immediately. (See Attachment D) =" " p=" "> =" " p=" "> =" " p=" "> =" " p=" "> =" " p=" ">	09/05/2024

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	This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 1) Based on observation, and interview; the facility failed to ensure 4 of 5 sprinkler heads located in the kitchen were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect as many as 12 residents, 6 staff and 2 visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 12:50 p.m.,	K 0353	=”” p=””> All Residents have the potential to be affected by this deficient practice. No Residents were affected by this deficient practice. Gardner Fire Protection was contacted on 08/27/2024 by the Regional Director to request replacement gauges and sprinkler heads identified during the facility tour as needing replaced. Gardner Fire Protection is scheduled to replace the sprinkler gauges and sprinkler heads identified during the facility tour on 09/23/2024. (See attachment E) The Maintenance Director or designee in conjunction with the preventative maintenance program will conduct monthly and weekly gauge inspections indefinitely, now noting the installation date of all sprinkler gauges. (See attachment F). Results of these inspections will be submitted to the Quality Assurance Committee for review. Any deficient practice will be corrected immediately. The Maintenance Director or designee will conduct monthly inspections on all sprinkler heads to ensure no	09/30/2024

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	four of the five sprinklers located in the kitchen area were green, covered with corrosion, and needed to be replaced. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned automatic sprinkler heads were covered in a green corrosion and needed to be replaced as soon as possible. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 5 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states 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 could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 1:10 p.m. to on 08/27/24, the facility has supervised dry and wet sprinkler systems and had a total of six and water pressure gauges. The manufacture date of 2019 was listed on the face of five sprinkler system gauge but the sixth was dated 2018 and was therefore over five years old and should have been replaced. No recalibration date information was affixed to the sprinkler system gauge either.		corrosion or debris is present. Should any sprinkler head be identified as corroded or having debris, Gardner Fire Protection will be contacted to replace corroded sprinkler heads. Any sprinkler head identified as having debris present will be cleaned by the Maintenance Director or designee. Results of these inspections will be submitted to the Quality Assurance Committee for review. Any deficient practice identified during the inspections will be corrected immediately. /p> ="" p=""> /p> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p="">	

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	Based on interview at the time of the observations, the Maintenance Director stated he did not know that the sprinkler system gauges had to be recalibrated of replaced within a five year period, but now that he did, he would contact his vendor and have all the gauges replaced at the same time so that they all would need to be replaced at the same time every five years as per the code. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			