

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b).</p> <p>Survey Date: 05/14/14</p> <p>Facility Number: 003734 Provider Number: 154050 AIM Number: 200404950A</p> <p>Surveyors: Amy Kelley, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Northeastern Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), 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.</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, in spaces open to the corridors and in patient rooms. The facility has a capacity of 16 and had a census of 9 at the time of this survey.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010018	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/20/14.</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 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 1 of 16 patient room corridor doors closed and latched into the door frame. This deficient practice could affect 1 of 9 patients.</p>	K010018	The door for Room 111 was fixed 5/21/14. Ron Green (Maintenance) is responsible	05/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2014	
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010038	<p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Foreman on 05/14/14 at 2:05 p.m., the corridor door to patient room 111 failed to latch into the door frame. This was acknowledged by the Maintenance Foreman at the time of observation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect patients evacuated through the 100 hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator, the Maintenance Foreman and the Maintenance Coordinator on 05/14/14 at 2:25 p.m., when exiting from the inpatient unit into the 100 hall there was a copier, file cabinet and a table stored in the 100 hall corridor. The was</p>	K010038	A plan to relocate the items in the exit corridor was submitted to maintenance 5/27/14 and will be completed by June 6, 2014 Jim Kelly (Administrator) is responsible.	06/06/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010050	<p>acknowledged by the Administrator and the Maintenance Foreman at the time of observation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report Form" with the Administrator on 05/14/14 at 12:30 p.m., a fire drill had not been conducted for the following:</p> <ul style="list-style-type: none"> a. first, second and third shifts for the fourth quarter of 2013. b. first and second shifts for the third quarter of 2013 c. first, second and third shifts for the 	K010050	Drills will be completed on each shift, 4 times a year. Each drill will be presented to Inpatient's Quality Council each month. Ronnie Philbin (DON) is responsible.	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2014
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K010062	<p>second quarter of 2013. Based on an interview with the Administrator at the time of record review, he acknowledged the facility had not conducted the required number of fire drills.</p> <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>Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. LSC 4.5.7 states whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. LSC 4.6.12 requires maintenance and testing of the automatic sprinkler system are made at specified intervals in accordance with applicable NFPA standards. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire</p>	K010062	<p>This has been introduced in the Northeastern calendar system to alert maintenance when this is due. Each quarter the water flow alarm system will be tested and reported to the Inpatient Quality Council. Also, quarterly the fire alarm will be shut down to ensure that our sprinkler inspection company receives our alarm. This will also be reported to the Inpatient Quality Council. Ron Green (Maintenance) is responsible.</p>	07/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Protection Systems, at 2-3.3 requires waterflow alarm devices including, but not limited to, mechanical water motor gongs, and pressure switches provide audible or visual signals shall be tested quarterly. Vane type waterflow devices may be tested semi-annually. NFPA 25, 9-4.4.2.1 requires the priming level shall be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires records shall indicate the procedure performed (inspection, test, or maintenance), the organization performed the work, the results and the date. Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator, the Maintenance Foreman and the Maintenance Coordinator on 05/14/14 at 2:15 p.m., the facility was unable to provide documentation of a sprinkler inspection for the third quarter</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2014	
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010144	<p>of 2013. After a telephone call was placed to the sprinkler inspection company, SimplexGrinnell, it was confirmed by the Maintenance Coordinator that a sprinkler inspection had not been conducted in the third quarter of 2013.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 8 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. NFPA 99, Section 3-4.1.1.8 states the generator set shall have</p>	K010144	The Northeastern person responsible for the generator tests will be trained on how to complete an inspection under load, by MacAllister July 18, 2014, and monthly tests will be done. Until then, MacAllister will complete the monthly test. A report on the generator weekly and monthly tests will be reported quarterly to the Inpatient Quality Council. Ron Green (Maintenance) is responsible.	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2014	
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>a. Based on record review of the untitled generator log with the Maintenance Foreman and the Maintenance Coordinator on 05/14/14 at 12:40 p.m., a generator load test was conducted quarterly. Based on an interview with the Maintenance Foreman at the time of record review, he thought the facility was only required to do a quarterly load test.</p> <p>b. Based on record review of the untitled generator log with the Maintenance Foreman and the Maintenance Coordinator on 05/14/14 at 12:42 p.m., the emergency generator was tested quarterly under load for at least 30 minutes, however, the load test record did not include the time for the transfer of power from the main source to the generator, the amps and the volts. This</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2014
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WESLEY RD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	was acknowledged by the Maintenance Foreman.				