

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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A000000	<p>This visit was for a follow-up Federal survey following a full Federal survey after a Federal complaint survey.</p> <p>Facility Number: 004975</p> <p>Survey Date: 09/08-09/2014</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>19 previously cited deficiencies were found corrected and 6 uncorrected deficiencies were recited (0117, 0166, 0171, 0178, 0700 and 0709).</p> <p>QA: cloughlin 09/12/14</p>	A000000		

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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A000117	<p>482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.</p> <p>Based on document review & interview, the facility failed to ensure that each patient and/or the responsible party was informed of their rights prior to receiving care or prior to discharge for 3 of 5 medical records (MR) reviewed (Patients #7, 8, and 9), failed to ensure that each patient and/or the responsible party was informed of their rights prior to discharge and failed to ensure the patient and/or responsible party signed the CMS form "AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS" for 2 of 5 MR reviewed (Patients #6 and 10).</p> <p>Findings include:</p> <p>1. Review of patient #7 (admitted 8/22/14 and discharged 9/5/14), #8 (admitted 8/1/14 and discharged 9/5/14) and #9 (admitted 8/15/14 and discharged 8/29/14) MRs indicated that each was a Medicare patient and each MR lacked documentation of receiving the "Important Message From Medicare" on admission & prior to discharge.</p>	A000117	<p>CMS PLAN OF CORRECTION 42-CFR §482.13-Patient Rights ID PREFIX TAG: A117 DATE DEFICIENCY WILL BE CORRECTED: 9/10/2014 WHAT IS THE PLAN OF CORRECTION: Information on Patient Rights, Responsibilities, Grievance Procedure, Advanced Directives, and Organ Donation will be provided to patients in advance of or when discontinuing any provision of care. HOW THE PLAN OF CORRECTION WILL OCCUR: The Patient Rights, Patient Responsibilities, Grievance Procedure, Advanced Directives and Organ Donation information will be updated to reflect the facilities current Policies and Procedures. A copy of this information will be placed in a packet and kept in a folder at the Registration desk and Nurses Stations. This packet will be provided to all patients at the time of admission or at the time any services are discontinued. Registration staff and nursing staff will be educated on this information and the need to provide copies of it at time of</p>	09/10/2014	

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A000166	<p>2. Review of patient #6 (admitted 9/4/14 and discharged 9/8/14) and #10 (admitted 8/17/14 and discharged 8/21/14) MRs indicated that each was a Medicare patient and each MR lacked documentation of receiving the "Important Message From Medicare" prior to discharge. Additionally, the patients signed a consent indicating they had received the patient rights information, however did not sign the document itself.</p> <p>3. On 9/9/14 at 11:50 a.m. staff member #2 (Quality Director) indicated in interview that the patients receive the Message from Medicare notice on admission only and not prior to discharge.</p> <p>4. On 9/9/14 beginning at 12:30 p.m. staff member #8 (Informatics RN) confirmed the medical record information above for patients #6-10.</p> <p>482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. Based on medical record review, facility</p>	A000166	<p>admission and/or discharge from facility. WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE; Rebecca Cook, Accounting Manager WHEN THE PLAN OF CORRECTION WILL BEGIN: 7/3/14 HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The Accounting Manager, who supervises the registration staff, will monitor the number of packets that are kept by the patients versus the number left in the box to monitor compliance. She will also periodically observe the registration process and monitor compliance. She will report her findings to the Quality Council monthly for 3 months, beginning in September 2014. At which time, the Quality Council will decide if continued monitoring is warranted.</p> <p>CMS PLAN OF CORRECTION 42-CFR §482.13-Patient Rights</p>	11/04/2014			

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	<p>policy review and staff interview, the facility failed to ensure modifications were made to the patients care plan after an episode of a restraint for 2 of 2 patient medical records reviewed (patient #3 and #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #3 medical record indicated the following: <ul style="list-style-type: none"> (A) An order was written for physical restraint at 7:50 p.m. on 8/21/14 and the restraint was utilized. (B) The medical record lacked evidence that the care plan was modified after the episode of restraint. Review of patient #4 medical record indicated the following: <ul style="list-style-type: none"> (A) An order was written for physical restraint at 6:50 a.m. on 7/14/14 and the restraint was utilized. (B) The medical record lacked evidence that the care plan was modified after the episode of restraint. Facility policy titled "Restraint Use-Medical and Behavioral" last reviewed/revised 4/14 states "...Update or modify the patients' health care plan to reflect the use of a restraint." Staff member #2 (Quality Director) 		<p>ID PREFIX TAG: A166 DATE DEFICIENCY WILL BE CORRECTED: 11/04/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital is now a "Restraint Free" facility. HOW THE PLAN OF CORRECTION WILL OCCUR: The CNO and Quality Director developed a Policy and Procedure for "Restraint Free" status of the facility and met with Department Directors to establish feasibility of the proposed policy. This Policy and Procedure was implemented as an interim until it could be approved by the Med Exec Board. The Med Exec Board approved the Policy and it has been implemented. In the event that Crisis Prevention Training interventions or techniques are required to become physical, or "hands on", and the temporary use of physical restraint is unavoidable, the House Supervisor must be notified and contact the AOC (Administrator on Call). Only the AOC has the authority to implement the previous Restraint Policy to ensure compliance with State and Federal Regulations and to assure the safety of patients and staff. The House Supervisor will be responsible for obtaining the appropriate,</p>		

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A000171	and #8 (Informatics RN) verified the medical record information above at 11:40 a.m. on 9/9/14. 482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used		time limited, order from the physician, updating the patient's healthcare plan, ensuring the face-to-face evaluation by the MD within one hour and ensuring all other documentation requirements are fulfilled. Staff will be educated on the new policy by way of "Read and Sign" in servicing. WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE,QD WHEN THE PLAN OF CORRECTION WILL BEGIN: 9/10/14 HOW THE DEFICIENCY REOCCURANCE WILL BE PREVENTED: The house supervisors and Unit Director/Manager will verify proper adherence to the Policy and Procedure, during chart audits, for no Physical or Chemical restraint use, or in the event that restraint of a patient is unavoidable, notification of AOC and adherence to the previous Restraint policy is done. This will be reported to the Quality Director, who will track and report to the Quality Council monthly beginning in November.		

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	<p>for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; Based on medical record review and staff interview, the facility failed to ensure an order for restraint was time limited in 1 of 2 (patient #3) and failed to ensure an order for restraint had appropriate time limits in 1 of 2 (patient #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #3 medical record indicated the following: (A) An order was written for physical restraint at 7:50 p.m. on 8/21/14. The order was not time limited. Review of patient #4 (age 84) medical record indicated the following: (A) An order was written for physical restraint at 8:55 a.m. on 7/14/14. The order was written for soft wrist restraints for 8 hours. Staff members #2 (Quality Director) and #8 (Informatics RN) verified the medical record information above at 	A000171	<p>CMS PLAN OF CORRECTION 42-CFR §482.13-Patient Rights ID PREFIX TAG: A171 DATE DEFICIENCY WILL BE CORRECTED: 11/04/2014 WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital is now a "Restraint Free" facility. HOW THE PLAN OF CORRECTION WILL OCCUR: The CNO and Quality Director developed a Policy and Procedure for "Restraint Free" status of the facility and met with Department Directors to establish feasibility of the proposed policy. This Policy and Procedure was implemented as an interim until it could be approved by the Med Exec Board. The Med Exec Board approved the Policy and it has been implemented. In the event that Crisis Prevention Training interventions or techniques are required to become physical, or "hands on", and the temporary use of physical</p>	11/04/2014			

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	11:40 a.m. on 9/9/14.		<p>restraint is unavoidable, the House Supervisor must be notified and contact the AOC (Administrator on Call). Only the AOC has the authority to implement the previous Restraint Policy to ensure compliance with State and Federal Regulations and to assure the safety of patients and staff. The House Supervisor will be responsible for obtaining the appropriate, time limited, order from the physician, updating the patient's healthcare plan, ensuring the face-to-face evaluation by the MD within one hour and ensuring all other documentation requirements are fulfilled. Staff will be educated on the new policy by way of "Read and Sign" in servicing. WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE,QD WHEN THE PLAN OF CORRECTION WILL BEGIN: 9/10/14 HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED: The house supervisors and Unit Director/Manager will verify proper adherence to the Policy and Procedure, during chart audits, for no Physical or Chemical restraint use, or in the event that restraint of a patient is unavoidable, notification of AOC and</p>		

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A000178	<p>482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention --</p> <ul style="list-style-type: none"> o By a-- <ul style="list-style-type: none"> - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. <p>Based on document review and staff interview, the facility failed to ensure a 1-hour face-to-face was conducted after implementation of a restraint order in 2 of 2 (patients #3 and 4) medical records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of patient #3 medical record indicated the following: <ol style="list-style-type: none"> (A) An order was written for soft wrist restraints to protect from hurting self and to prevent pulling out IV and taking off 	A000178	<p>adherence to the previous Restraint policy is done. This will be reported to the Quality Director, who will track and report to the Quality Council monthly beginning in November.</p> <p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.13-Patient Rights</p> <p>ID PREFIX TAG: A178</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 11/04/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: Saint Catherine Regional Hospital is now a "Restraint Free" facility.</p>	11/04/2014	

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	<p>oxygen at 7:50 p.m. on 8/21/14 and the restraint was initiated.</p> <p>(B) The medical record lacked evidence that a face-to-face was conducted within 1 hour of the initiation of the restraint.</p> <p>2. Review of patient #4 medical record indicated the following:</p> <p>(A) An order was written for soft wrist restraints to prevent pulling out IV and taking off oxygen at 8:55 a.m. on 7/14/14 and the restraint was initiated.</p> <p>(B) The medical record lacked evidence that a face-to-face was conducted within 1 hour of the initiation of the restraint.</p> <p>3. Staff members #2 (Quality Director) and #8 (Informatics RN) verified the medical record information above at 11:40 a.m. on 9/9/14.</p>		<p>HOW THE PLAN OF CORRECTION WILL OCCUR: :</p> <p>The CNO and Quality Director developed a Policy and Procedure for "Restraint Free" status of the facility and met with Department Directors to establish feasibility of the proposed policy. This Policy and Procedure was implemented as an interim until it could be approved by the Med Exec Board. The Med Exec Board approved the Policy and it has been implemented. In the event that Crisis Prevention Training interventions or techniques are required to become physical, or "hands on", and the temporary use of physical restraint is unavoidable, the House Supervisor must be notified and contact the AOC (Administrator on Call). Only the AOC has the authority to implement the previous Restraint Policy to ensure compliance with State and Federal Regulations and to assure the safety of patients and staff. The House Supervisor will be responsible for obtaining the appropriate, time limited, order from the physician, updating the patient's healthcare plan, ensuring the face-to-face evaluation by the MD within one hour and ensuring all other</p>		

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			<p>documentation requirements are fulfilled. Staff will be educated on the new policy by way of "Read and Sign" in servicing.</p> <p>WHO IS RESPONSIBLE: Ginger Ottersbach RN,CNO; Kimmie C. Perra RN, NE,QD</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 9/10/14</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The house supervisors and Unit Director/Manager will verify proper adherence to the Policy and Procedure, during chart audits, for no Physical or Chemical restraint use, or in the event that restraint of a patient is unavoidable, notification of AOC and adherence to the previous Restraint policy is done. This will be reported to the Quality Director, who will track and report to the Quality Council monthly beginning in November.</p>	

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A000700	<p>482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.</p> <p>Based on Life Safety Code (LSC) survey, Saint Catherine Regional Hospital 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 three story hospital was determined to be of Type II (222) construction with a basement and partially sprinkled. The basement kitchen, dining room, and old bathroom; the first floor physical therapy room and the gift shop; and the third floor hyperbaric chamber room were sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The facility has a capacity of 47 and had a census of 23 at the time of this survey.</p> <p>Based on LSC survey and deficiencies</p>	A000700	<p>CMS PLAN OF CORRECTION 42-CFR §482.41 Physical Environment ID PREFIX TAG: A700 DATE DEFICIENCY WILL BE CORRECTED: 10/31/2014 WHAT IS THE PLAN OF CORRECTION: There is an individual Plan of Correction for each Physical Environment issue sited in the survey conducted on 6/4/2014. Each Plan of Correction has it's own correction date. The date listed above is the latest date noted. HOW THE PLAN OF CORRECTION WILL OCCUR: Please refer to each Plan of Correction submitted. WHO IS RESPONSIBLE: Dave Millet, Facilities Director; Maintenance Staff WHEN THE PLAN OF CORRECTION WILL BEGIN: 6/4/2014 HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED: Please refer to each Plan of Correction submitted. ID PREFIX TAG: K 020 DATE DEFICIENCY WILL BE CORRECTED: Deficiency will be corrected by October 2014.</p>	10/31/2014
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	<p>found (see CMS 2567L), it was determined that the facility failed to ensure vertical opening protection for 2 of 4 basement exit stairwells (see K 020), failed to ensure 1 of 9 third floor sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes (see K 027), failed to ensure 27 of 67 smoke detectors tested for sensitivity were either cleaned and recalibrated or replaced (see K 051), failed to ensure 3 of 3 sprinkler system gauges were replaced or recalibrated every 5 years (see K 062) and failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurse station and failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop (see K 144).</p> <p>The cumulative effect of these systemic problems resulted in the hospital's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.</p>		<p>WHAT IS THE PLAN OF CORRECTION: The doors to the basement stairwell were assessed for repair. Due to the age of the doors and their unusual design we worked with the manufacturer to find parts for the repair on the mechanisms. These parts have been ordered and we are awaiting delivery. The doors will be repaired when the parts are delivered. HOW THE PLAN OF CORRECTION WILL OCCUR: Repairs will be completed when the parts become available. WHO IS RESPONSIBLE: Director of Facilities Management WHEN THE PLAN OF CORRECTION WILL BEGIN: The correction will be completed within 30 days of the receipt of the needed parts. HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities. ID PREFIX TAG: K 027 DATE DEFICIENCY WAS CORRECTED: September 26,2014 WHAT IS THE PLAN OF CORRECTION: The smoke barrier doors, located on the 3rd floor were replaced with new ones on September 26, 2014. HOW THE PLAN OF CORRECTION WILL OCCUR: Smoke barrier doors were</p>		

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			<p>replaced on the 3rd floor on September 26, 2014.. WHO IS RESPONSIBLE: Director of Facilities Management WHEN THE PLAN OF CORRECTION WILL BEGIN: The correction was completed on September 26, 2014 HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities. ID PREFIX TAG: K 051 DATE DEFICIENCY WILL BE CORRECTED: Deficiency will by corrected on October 2014</p> <p>WHAT IS THE PLAN OF CORRECTION: The first fifteen smoke detectors were replaced in July of 2013. The second 15 detectors were replaced in September. The remaining detectors will be installed by the end of October 2014. While replacement of remaining smoke detectors is pending, the facility has initiated fire watches to ensure safety standards are maintained pending completion.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Koorsen Fire & Security have installed the first and second rounds of the fifteen smoke detectors. The remaining detectors will be scheduled to be installed by the end of October 2014. WHO IS RESPONSIBLE: Director of Facilities Management</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
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			<p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The plan of correction is in progress. The remaining smoke detectors will be installed by the end of October 2014. HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:The smoke detectors will upgrade the fire systems of the hospital. The new devices will be tested on a regular schedule. ID PREFIX TAG: K 062 DATE DEFICIENCY WILL BE CORRECTED: Deficiency will be corrected by October 2014</p> <p>WHAT IS THE PLAN OF CORRECTION: The gauges on the sprinkler system/fire pump have been ordered from Koorsen Fire & Security. The company states they are in and that they will be installed upon their next scheduled visit to replace the smoke detectors in October.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Koorsen Fire & Security will be here to replace the last 15 smoke detectors in October, and will replace the 3 gauges at that time. WHO IS RESPONSIBLE: Director of Facilities Management WHEN THE PLAN OF CORRECTION WILL BEGIN: The new gauges were ordered from Koorsen Fire & Security on June 24, 2014. The company states they are in and admits that their worker failed to bring the gauges on the last visit</p>		

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			<p>to replace the smoke detectors.</p> <p>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED: The gauges are included in the fire systems inspection each quarter. The fire/sprinkler system gauges will monitored and replaced every five years. ID PREFIX TAG: K 144</p> <p>DATE DEFICIENCY WILL BE CORRECTED: Deficiency was corrected on October 6, 2014</p> <p>WHAT IS THE PLAN OF CORRECTION: The hospital contracted Whayne Supply to install a remote manual shut-off for the generator as well as generator alarm annunciators at the reception desk, which is manned at all times, and the operators station, which is open during regular business hours.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Whayne Supply installed 2 generator alarm annunciators, one at the receptionist desk and one at the operators station, and one emergency shut off valve for the generator, which was installed on the exterior housing of the generator. The installation of all three components was completed on 10/6/14. WHO IS RESPONSIBLE: Director of Facilities Management WHEN THE PLAN OF CORRECTION WILL BEGIN: The company was contacted on June 19, 2014. A quote was received by June 30, 2014, work was completed October 6, 2014. HOW THE</p>		

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A000709	<p>482.41(b) LIFE SAFETY FROM FIRE Life Safety from Fire</p> <p>Based on observation, document review and interview, the facility failed to ensure vertical opening protection for 2 of 4 basement exit stairwells, failed to ensure 1 of 9 third floor sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes, failed to ensure 27 of 67 smoke detectors tested for sensitivity were either cleaned and recalibrated or replaced, failed to ensure 3 of 3 sprinkler system gauges were replaced or recalibrated every 5 years and failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurse station and failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop.</p> <p>Findings:</p> <p>1. Observations on 08/12/14 during a tour of the facility with DF1, Director of Facilities, from 10:50 a.m. to 11:15 a.m. noted the kitchen stairway door and the canteen area stairway door each failed to</p>	A000709	<p>DEFICIENCY REOCCURRENCE WILL BE PREVENTED:The installation of the equipment is a permanent installation.</p> <p>CMS PLAN OF CORRECTION</p> <p>42-CFR §482.41 Physical Environment</p> <p>ID PREFIX TAG: A709 DATE DEFICIENCY WILL BE CORRECTED: 10/31/2014</p> <p>WHAT IS THE PLAN OF CORRECTION: There is an individual Plan of Correction for each Physical Environment issue sited in the survey conducted on 6/4/2014. Each Plan of Correction has it's own correction date. The date listed above is the latest date noted.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Please refer to each Plan of Correction submitted.</p> <p>WHO IS RESPONSIBLE: Dave millet, Facilities Director; Maintenance Staff</p>	10/31/2014

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	<p>self close and latch into the door frame, leaving a one inch gap along the latching side of the doors.</p> <p>2. In interview with DF1 on 08/12/14 at 10:45 a.m., it was indicated that two new doors were ordered for the kitchen stairway and the canteen area stairway but the facility is still waiting for the doors to arrive.</p> <p>3. Observation on 08/12/14 at 11:10 a.m. with DF1 noted the third floor set of smoke barrier doors by room 363 was not provided with self closing devices to form a smoke resistive barrier and lacked the hardware to open each door, leaving a four inch by three inch open area in each door.</p> <p>4. In interview with DF1, it was indicated that new door closers and opening hardware has been ordered for the set of smoke barrier doors but has not been received and installed.</p> <p>5. Based on a review of contracted Fire & Security Detector Sensitivity Test Reports dated 09/17/12 and 09/25/12 with DF1 on 08/12/14 at 10:30 a.m. indicated the reports listed fifty-seven smoke detectors failed sensitivity testing. Contracted Work Order report dated 7/14/13 indicated the Tech replaced 15</p>		<p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 6/4/2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: Please refer to each Plan of Correction submitted.</p> <p>ID PREFIX TAG: K 020</p> <p>DATE DEFICIENCY WILL BE CORRECTED: Deficiency will be corrected by October 2014.</p> <p>WHAT IS THE PLAN OF CORRECTION: The doors to the basement stairwell were assessed for repair. Due to the age of the doors and their unusual design we worked with the</p>				

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	<p>smoke detectors and the report dated 07/24/14 listed an additional twenty smoke detectors which had been replaced.</p> <p>6. In interview with DF1 on 08/12/14 at 10:40 a.m., it was stated the contractor ordered the remaining twenty-seven smoke detectors which needed replaced from the 09/17/12 and 09/25/12 reports listing them as failing sensitivity testing, but the contractor has yet to receive the twenty-seven replacement smoke detectors.</p> <p>7. Review of Quarterly Sprinkler System Inspection Reports from 03/17/14 through 01/03/13 with DF1 on 08/12/14 at 10:40 a.m. indicated there was no record of the three sprinkler system gauges having been replaced over the past five years.</p> <p>8. In interview with DF1 on 08/12/14 at 10:45 a.m., it was indicated that the contractor has ordered the three gauges for the sprinkler riser but have not made the repair yet.</p> <p>9. Observation on 08/12/14 at 10:55 a.m. during a tour of the facility with DF1, it was noted there was no remote alarm annunciator for the emergency generator in a location readily observed by</p>		<p>manufacturer to find parts for the repair on the mechanisms. These parts have been ordered and we are awaiting delivery. The doors will be repaired when the parts are delivered.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Repairs will be completed when the parts become available.</p> <p>WHO IS RESPONSIBLE: Director of Facilities Management</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The correction will be completed within 30 days of the receipt of the needed parts.</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p>ID PREFIX TAG: K 027</p> <p>DATE DEFICIENCY WAS CORRECTED: September 26,2014</p> <p>WHAT IS THE PLAN OF CORRECTION: The smoke barrier doors, located on the 3rd floor were replaced with new</p>				

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	<p>operating personnel at a regular work station such as a nurse station. Furthermore, the only remote alarm annunciator for the generator was located in the Business Office which was not occupied at all times.</p> <p>10. In interview with DF1 on 08/12/14 at 11:15 a.m., it was indicated a new remote alarm annunciator has been ordered but has not been received and installed.</p> <p>11. Observation on 08/12/14 at 11:10 a.m., during a tour of the facility with DF1, it was noted that a remote shut off device for the over 150 horsepower generator was not found.</p> <p>12. In interview with DF1 on 08/12/14 at 11:15 a.m., it was indicated a remote shut off device has been ordered for the emergency generator set but it has not been received and installed.</p>		<p>ones on September 26, 2014.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Smoke barrier doors were replaced on the 3rd floor on September 26, 2014..</p> <p>WHO IS RESPONSIBLE: Director of Facilities Management</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The correction was completed on September 26, 2014</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p>ID PREFIX TAG: K 051</p> <p>DATE DEFICIENCY WILL BE CORRECTED: Deficiency will by corrected on October 2014</p> <p>WHAT IS THE PLAN OF CORRECTION:</p>		

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			<p>The first fifteen smoke detectors were replaced in July of 2013. The second 15 detectors were replaced in September. The remaining detectors will be installed by the end of October 2014. While replacement of remaining smoke detectors is pending, the facility has initiated fire watches to ensure safety standards are maintained pending completion.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: Koorsen Fire & Security have installed the first and second rounds of the fifteen smoke detectors. The remaining detectors will be scheduled to be installed by the end of October 2014.</p> <p>WHO IS RESPONSIBLE: Director of Facilities Management</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The plan of correction is in progress. The remaining smoke detectors will be installed by the end of October 2014.</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The smoke detectors will upgrade the fire systems of the hospital. The new devices will be tested on a regular schedule.</p> <p>ID PREFIX TAG: K 062</p>	

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			<p>DATE DEFICIENCY WILL BE CORRECTED:</p> <p>Deficiency will be corrected by October 2014</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>The gauges on the sprinkler system/fire pump have been ordered from Koorsen Fire & Security. The company states they are in and that they will be installed upon their next scheduled visit to replace the smoke detectors in October.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>Koorsen Fire & Security will be here to replace the last 15 smoke detectors in October, and will replace the 3 gauges at that time.</p> <p>WHO IS RESPONSIBLE:</p> <p>Director of Facilities Management</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p> <p>The new gauges were ordered from</p>		

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			<p>Koorsen Fire & Security on June 24, 2014. The company states they are in and admits that their worker failed to bring the gauges on the last visit to replace the smoke detectors.</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</p> <p>The gauges are included in the fire systems inspection each quarter. The fire/sprinkler system gauges will monitored and replaced every five years.</p> <p>ID PREFIX TAG: K 144</p> <p>DATE DEFICIENCY WILL BE CORRECTED:</p> <p>Deficiency was corrected on October 6, 2014</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>The hospital contracted Whayne Supply to install a remote manual shut-off for the generator as well as generator alarm annunciators at the reception desk, which is manned at all times, and the operators station, which is open during regular business hours.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p>	

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			<p>Whayne Supply installed 2 generator alarm annunciators, one at the receptionist desk and one at the operators station, and one emergency shut off valve for the generator, which was installed on the exterior housing of the generator. The installation of all three components was completed on 10/6/14.</p> <p>WHO IS RESPONSIBLE: Director of Facilities Management</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: The company was contacted on June 19, 2014. A quote will be received by June 30, 2014, work was completed October 6, 2014.</p> <p>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED: The installation of the equipment is a permanent installation.</p>		