

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151300	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL OF BREMEN INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 HIGH RD BREMEN, IN 46506
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K020000	<p>A Life Safety Code Recertification survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).</p> <p>Survey Date: 08/05/14</p> <p>Facility Number: 005097 Provider Number: 151300 AIM Number: 100269320A</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Hospital of Bremen Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(d), 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.</p> <p>This one story facility was fully sprinklered and determined to be of Type II (III) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 24 and had a census of 2 at the time of</p>	K020000		
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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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K020018	<p>the survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/11/14.</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 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 2 of 2 sets of double corridor doors closed and latched automatically into the door frame. This deficient practice would not directly affect patients but could affect staff and visitors.</p> <p>Findings includes:</p> <p>Based on observations with the Director of Plant Operations on 08/05/14 from 2:30 p.m. to 3:45 p.m., the entrance to the Plant Operations/Information Services</p>	K020018	<p>It is our professional understanding that the operable leaf at the two locations noted fully meets the requirements of Life Safety Code (LSC) 721 for width and operation. The other leaf serves only as additional width for maintenance operations through the opening or as an aesthetic design feature and therefore is not required to meet the requirements of 721. In lieu of this objection, a contractor has been contacted to provide suggested options in resolving this noted deficiency. Recommendations are expected to be received by 8/30/14 with</p>	09/30/2014

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K020032	<p>Area (Door # 410) and the entrance to the Administrative area were provided with a set of double corridor doors equipped with a slide bolt latch on one door which had to be manually latched to allow the other door to latch into the first door. The Director of Plant Operations at the time of observation acknowledged the doors would not automatically latch.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD No less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 18.2.4.1, 18.2.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridors in the Obstetrics (OB) area was provided access to not less than two approved exits. LSC 18.2.5.9 requires every corridor shall provide access to not less than two approved exits in accordance with sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. This deficient practice could affect any patient, staff or visitor in the OB area.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 08/05/14 from 2:30</p>	K020032	<p>work completed by 9/30/14 Continuous monitoring will be implemented to assure any new construction or renovation complies with this standard Any contractor will be made aware of this deficiency citation to assure their understanding of the requirements</p> <p>A contractor has been contacted to add exit signage and card access to the second corridor exit noted in the citation In addition, the exit door will be included in the infant abduction security system alarms for the OB area Contract work to be completed within 30 days of start - all work to be completed by 10/31/14 Continuous monitoring will be implemented to assure any new construction or renovation complies with this standard Any contractor will be made aware of this deficiency citation to assure their understanding of the requirements</p>	10/31/2014	

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K020045	<p>p.m. to 3:45 p.m., the fifty five foot long OB corridor was provided with one marked exit on one end of the corridor. On the opposite end of the corridor, there were two unmarked exit options. The first option was exiting with a staff access card through a magnetically locked door into an intervening nurses station before reaching the corridor. The second available option was exiting through a door leading directly to the corridor that was magnetically locked but could only be opened when the fire alarm was activated. Based on interview at the time of observation, the Director of Plant Operations acknowledged the OB corridor had only one approved, readily visible exit.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8</p> <p>Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 6 emergency exits. LSC 7.8.1.3 requires the walking surface within the portions of the exit discharge to be illuminated to values of at least 1 foot candle of light. This deficient</p>	K020045	Contractor bids are being obtained to install egress lighting on the emergency exit identified in the survey Lighting to be installed on the rooftop of the building to illuminate the walkway from the west exit to the southeast parking lot and to the path along the west of the	10/31/2014

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K020050	<p>practice could affect patients on the west hall who could be evacuated through the west exit.</p> <p>Finding include:</p> <p>Based on observation with the Director of Plant Operations on 08/05/14 from 2:30 p.m. to 3:45 p.m., the exterior exit discharge path for the west exit was not equipped with light fixtures. The exterior exit discharge path extended at least 100 feet away from the building and continued to both the north and the south for at least 200 feet without illumination. Based on an interview at the time of observation, the Director of Plant Operations acknowledged the exit discharge path from the west exit lacked illumination.</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</p>		<p>building to the northwest parking lot All work to be completed by 10/31/14</p> <p>Continuous monitoring will be implemented to assure any new construction or renovation complies with this standard Any contractor will be made aware of this deficiency citation to assure their understanding of the requirements</p>				

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	<p>audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 3 of 6 fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters included the verification of transmission of the fire alarm signal to the monitoring station in fire the drill records. LSC 18.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all patients in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 08/05/14 at 1:00 p.m. with the Director of Plant Operations, the documentation for the following drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills: on 05/38/14 at 8:00 p.m., on 04/22/14 at 6:15 a.m., and on 01/31/14 at 8:00 a.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the transmission of the fire alarm signal for the aforementioned fire drills was not documented.</p>	K020050	A Quality Initiative focused on the execution of monthly fire drills has been created All employees conducting fire drills were re-educated on the fire drill procedure and a report will be generated for each future drill to log fire drill times, which will then be checked against the fire alarm activity log from Tyco to insure compliance The Quality Initiative will be added to the departmental quality improvement program for Plant Operations, and results monitored through the Quality Improvement Committee and Environment of Care Committee to monitor ongoing compliance	08/14/2014	

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K020144	<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 ensure 1 of 1 diesel generators was exercised annually under supplemental load. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, section 6-4.2.2 states diesel powered emergency power supply (EPS) installations that do not meet the requirements of section 6-4.2 shall be exercised monthly with the available emergency power supply system (EPSS) load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all patients as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review the most recent load bank test which occurred on 04/25/13 and interview with the Director of Plant Operations on 08/05/14 at 2:00 p.m., the diesel powered generator does not</p>	K020144	<p>A load bank test is scheduled to be completed 9/3/14 A work order and calendar notice has been developed to identify the need for a load bank test to be performed annually on an ongoing basis, with the notice generated 30 days prior to the end of the 12 month period, which will allow sufficient time to schedule the load bank test within the last month of the 12 month annual timeframe Annual load bank testing will be included in the Plant Operations quality indicators and reported annually to the Quality Improvement Committee</p>	09/03/2014

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K020154	<p>achieve 30 percent of the nameplate rating when run under load and the facility has a load bank test conducted by an outside contractor on a yearly basis. Based on interview at the time of record review, the Director of Plant Operations acknowledged the most recent load bank test occurred more than twelve months ago.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, section 9.7.6.1 in order to protect 2 of 2 patients. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems.</p>	K020154	Hospital Policy #PO072 - Fire Watch - was amended to include Indiana State Board of Health in both initial notification of fire watch implementation and re-notification when fire watch is terminated	08/06/2014			

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K020155	<p>NFPA 25, 1-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Plant Operations on 08/05/14 at 2:15 p.m., the facility had a fire watch procedure for a sprinkler system failure but it did not address all components of LSC 9.7.6.1. Specifically, the plan did not include notification of the outage to the Indiana State Department of Health which is one of the authorities having jurisdiction.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event</p>	K020155	Hospital Policy #PO072 - Fire Watch - was amended to include Indiana State Board of Health in both initial notification of fire	08/06/2014			

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	<p>the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 2 of 2 patients. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Plant Operations on 08/05/14 at 2:15 p.m., the facility had a fire watch procedure for a fire alarm system failure, but it did not address all components of LSC Section 9.6.1.8. Specifically, the plan did not include notification of the outage to the Indiana State Department of Health which is one of the authorities having jurisdiction.</p>		<p>watch implementation and re-notification when fire watch is terminated</p>		