

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G048	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/08/2014
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NAME OF PROVIDER OR SUPPLIER  BETHESDA LUTHERAN COMMUNITIES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 N NICHOLS ST LOWELL, IN 46356
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 09/08/2014</p> <p>Facility Number: 000603 Provider Number: 15G048 AIM Number: 100233510</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bethesda Lutheran Communities, Inc was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was determined to be non-sprinklered. The facility has a fire alarm system with hard wired smoke detection on all levels, corridors, resident bedrooms and common living areas. The facility has the capacity for 6 and had a census of 5 at the time of this survey.</p>	K010000		
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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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K01S119	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.76.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/09/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Other hazardous areas are protected in accordance with 33.2.3.2.3 by one of the following:</p> <p>(1) An enclosure having a fire resistance rating of not less than ½ hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 1¼ inch (4.4 cm) thick, solid-bonded wood core construction.</p> <p>(2) Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas were protected with self-closing or automatic closing doors and the walls were smoke resistant. This deficiency</p>	K01S119	The door to this storage area will be replaced with a 1 3/4 inch thick, solid bonded wood core construction door and self-closing hinges will be added. The four penetrations at the top of the wall	10/08/2014

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K01S155	<p>could affect all staff and clients residing in the home.</p> <p>Findings include:</p> <p>During a tour of the facility with the Program Manager, on 09/08/04 at 10:20 A.M., the basement contained a storage room which housed multiple filing cabinets with stored paper records as well as multiple stacked cardboard file boxes which also stored paper documents. Interview with the Program Manager during the observation indicated the room was solely used to store paper documents from files. The wall separating the room from the rest of the basement had four penetrations at the top where conduit or wiring went through the wall. There was a gap in each penetration up to 1 inch which could allow smoke or heat to penetrate outside the hazardous area. Additionally the door to this room was not self-closing or equipped with an automatic door closer.</p> <p>483.470(j)(1)(i) 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 shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire</p>		will be patched with a flame retardant filler/plaster. Any modification or changes made to the building or changes in the usage of rooms will be checked out to ensure that it meets the Life Safety Code Standards prior to the change or modification being made. The Program Director will be responsible to ensure that this is done. Plans will be reviewed by the Risk Management Team prior to the changes being made.				

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	<p>alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system is out of service for 4 hours or more in a 24 hour period. LSC A.9.6.1.8 explains a fire watch should at least involve some special action beyond normal staffing. Those individuals should be specifically trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education purposes. This deficient practice affects all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the undated "Fire Watch Policy/Procedure" during record review from 9:35 A.M. to 10:20 a.m. on 09/08/2014, the policy/procedure stated "The Program Manager shall designate a trained staff person to complete the fire watch procedures for each shift." Interview with the Program Manager at 10:05 A.M. indicated the staff person assigned would be "whoever the staff person is on duty" would be the person responsible to complete the fire watch. The program manager indicated the</p>	K01S155	The Fire Watch Policy/Procedure has been modified to address that the person conducting the fire watch will have no other responsibilities during the fire watch. If single staffed, an additional person will be called in to work. Staff conducting the fire watch will also be current on their fire safety training. All staff will be trained on this revised policy. The Fire Watch Policy/Procedure will be reviewed annually by the Management team to ensure that it meets the intent of the Life Safety Code.	10/08/2014			

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	person assigned would make the rounds and complete the log in addition to their assigned direct care duties.				