

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2015
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NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN 47274
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(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
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/20/15</p> <p>Facility Number: 003342 Provider Number: 155712 AIM Number: 200403740</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Covered Bridge Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), 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, and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the</p>	K 000		
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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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K 018 SS=E Bldg. 01	<p>corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 78 and had a census of 64 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/25/15.</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</p>			

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure the 12 of 36 resident room corridor room doors would resist the passage of smoke. This deficient practice could affects 24 residents who reside in rooms 201, 202, 204, 205, 206, 207, 209, 210, 106, 107, 112, and 113.</p> <p>Findings include:</p> <p>Based on observations with the director of plant operations on 02/20/15 during a tour of the facility from 9:40 a.m. to 12:45 p.m., resident rooms 201, 202, 204, 205, 206, 207, 209, 210, 106, 107, 112, and 113 doors each had between a one half inch and two inch gap from the door latches to the top latching sides of the doors with the doors closed. This was verified by the director of plant operations at the time of observations and acknowledged by the director of nursing at the exit conference on 02/20/15 at 12:55 p.m.</p> <p>3.1-19(b)</p>	K 018	<p>K 018</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: We have removed the wreath holders from all doors. We are putting smoke barrier tape on doors that have not met the Life Safety Requirement.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: We have inspected all doors throughout the campus.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur. Upon admission all residents and families will be informed that wire wreath holders are unacceptable.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does</p>	03/22/2015	

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K 027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply	K 027	not recur: Plant Operations or his designee will audit 3 times per week x 3 months, 2 times per week x 3 mths and 1 time per week x 3 mths. The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations. March 22, 2015 K 027 Corrective actions accomplished for those	03/22/2015

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	<p>with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 24 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/20/15 at 11:30 a.m. with the director of plant operations, the 200 Hall set of smoke barrier doors had a one inch gap along the length of the door where the doors came together in the closed position. This was verified by the director of plant operations at the time of observation and acknowledged by the director of nursing at the exit conference on 02/20/15 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p>residents found to be affected by the alleged deficient practice: Doors will be adjusted to close appropriately on 200 Hall.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All fire doors will be checked and adjusted as needed.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Will be added to our monthly Preventative Maintenance checklist.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Plant Operations or his designee will audit 1 x per week times 6 mths.</p> <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for</p>		

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K 046 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 4 of 35 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p>	K 046	<p>a minimum of 6 months then randomly thereafter, for further recommendations.</p> <p style="text-align: right;">March 22, 2015</p> <p>K 046</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: We have confirmed with Koorsen Fire Protection we have 36 battery back-up lights.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Verified with Koorsen we have 36 battery back-up lights.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur.</p>	02/27/2015

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	<p>Findings include:</p> <p>Based on record review on 02/20/15 at 9:35 a.m. with the director of plant operations, the facility had an Emergency Lighting Log listing thirty five battery backup lights and their locations indicating monthly tests performed. Based on a review of the Koorsen Fire & Security report dated 06/13/14, an annual ninety minute test was performed on thirty one battery backup lights, but the Koorsen Fire & Security report dated 06/13/14 failed to list the locations of the battery backup lights and had a total of thirty one battery backup lights tested, which was four battery backup lights different from the the director of plant operations monthly Emergency Lighting Log. Based on an interview with the director of plant operations on 02/20/15 at 9:40 a.m., the monthly Emergency Lighting Log has the correct number of battery backup lights listed and the Koorsen Fire & Security report date 06/13/14 is four battery backup lights short of the total number in the facility. The lack of the annual ninety minute test report not listing the location of the battery backup lights tested and four lights not tested from the total number of battery backup lights in the facility was verified by the director of plant operations at the time of record review</p>		<p>Koorsen visited and toured the campus with DPO and verified we have 36 battery back-up lights and they were tested during the visit on February 27, 2015.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DPO will monitor monthly on-going as part of his Preventive Maintenance Schedule</p> <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p> <p>Feb. 27, 2015</p>		

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K 062 SS=E Bldg. 01	<p>and interview and acknowledged by the director of nursing at the exit conference on 02/20/15 at 12:55 p.m.</p> <p>3.1-19(b)</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 observation and interview, the facility failed to ensure 18 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 33 residents who use the main dining room located next to the kitchen, 21 residents who reside on the 100 Hall, and 22 resident who reside in rooms 103, 106, 113, 114, 201, 203, 209, 210, 301, 304, and 306.</p> <p>Findings include:</p> <p>Based on observations on 02/20/15 during a tour of the facility from 9:40 a.m. to 12:45 p.m. with the director of plant operations, the following sprinkler escutcheons had between a one half inch and two inch gap between the ceiling and the attic space above where the sprinkler escutcheon was not tight fitting to the ceiling: resident rooms 103, 106, 113,</p>	K 062	<p>K 062</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Landmark Sprinkler will repair all sprinkle escutcheon.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All sprinklers throughout the building will be checked and repaired as needed by Landmark Sprinkler.</p> <p>Measures put in place and systemic changes made to</p>	03/22/2015

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K 000 Bldg. 02	<p>114, 201 bathroom, 203, 209, 210, 301, 304, 306, the kitchen sprinkler by the refrigerator, the living room, the Administration Hall library, and the 100 Hall corridor by room 112. This was verified by the director of plant operations at the time of observations and acknowledged by the director of nursing at the exit conference on 02/20/15 at 12:55 p.m.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/20/15</p>	K 000	<p>ensure the alleged deficient practice does not recur. DPO will inspect during his room preventative maintenance reviews.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Plant Operations or his designee will audit 1 x a month and on-going.</p> <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p> <p style="text-align: right;">March</p> <p>22, 2015</p>	

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	<p>Facility Number: 003342 Provider Number: 155712 AIM Number: 200403740</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Covered Bridge Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 2005 300 Hall four resident room addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The 300 Hall addition is a fully sprinkled one story addition of Type V (111) construction. The 300 Hall addition has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 78 and had a census of 64 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were</p>			

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K 046 SS=E Bldg. 02	<p>sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/25/15.</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 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review and interview, the facility failed to ensure 4 of 35 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for</p>	K 046	<p>K 046</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: We have confirmed with Koorsen Fire Protection we have 36 battery back-up lights.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Verified with Koorsen we have 36 battery back-up lights.</p>	02/27/2015

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	<p>inspection by the authority having jurisdiction. This deficient practice could affect all residents who reside on the 300 Hall.</p> <p>Findings include:</p> <p>Based on record review on 02/20/15 at 9:35 a.m. with the director of plant operations, the facility had an Emergency Lighting Log listing thirty five battery backup lights and their locations indicating monthly tests performed. Based on a review of the Koorsen Fire & Security report dated 06/13/14, an annual ninety minute test was performed on thirty one battery backup lights, but the Koorsen Fire & Security report dated 06/13/14 failed to list the locations of the battery backup lights and had a total of thirty one battery backup lights tested, which was four battery backup lights different from the the director of plant operations monthly Emergency Lighting Log. Based on an interview with the director of plant operations on 02/20/15 at 9:40 a.m., the monthly Emergency Lighting Log has the correct number of battery backup lights listed and the Koorsen Fire & Security report date 06/13/14 is four battery backup lights short of the total number in the facility. The lack of the annual ninety minute test report not listing the location of the</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur.</p> <p>Koorsen visited and toured the campus with DPO and verified we have 36 battery back-up lights and they were tested during the visit on February 27, 2015.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DPO will monitor monthly on-going as part of his Preventive Maintenance Schedule</p> <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p> <p>Feb. 27, 2015</p>				

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	battery backup lights tested and four lights not tested from the total number of battery backup lights in the facility was verified by the director of plant operations at the time of record review and interview and acknowledged by the director of nursing at the exit conference on 02/20/15 at 12:55 p.m. 3.1-19(b)				