

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155593	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/07/2016
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NAME OF PROVIDER OR SUPPLIER  INDIANA MASONIC HOME HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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K 0000  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: 03/07/16</p> <p>Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430</p> <p>At this Life Safety Code survey, Indiana Masonic Home Health Center 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.</p> <p>This three story facility with a basement was determined to be of Type I (332) construction and was fully sprinklered except for the laundry garage area. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in TCU resident</p>	K 0000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, In (the "Facility") that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner The Facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 Programs) To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility It is thus submitted as a matter of stature only The facility respectfully requests a desk review for this survey Plan of Correction</p>	
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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 0056 SS=D Bldg. 01	<p>sleeping rooms on the second floor and has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The certified portion of the facility has a capacity of 173 and had a census of 122 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the laundry garage area.</p> <p>Quality Review completed on 03/10/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 basement laundry garages was completely sprinklered. This deficient practice affects staff only who work in either the laundry</p>	K 0056	K 056 The corrective action accomplished for those staff found to have been affected by the deficient practice was the installation of sprinkler coverage in the basement laundry garage	03/21/2016

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K 0069 SS=D Bldg. 01	<p>department or the maintenance department.</p> <p>Findings include:</p> <p>Based on observation on 03/07/16 at 11:20 a.m. with the maintenance supervisor, the basement laundry garage lacked sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/07/16 at 1:45 p.m.</p> <p>3.1-19 (b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3</p>	K 0069	<p>area. Sprinkler coverage was added to the affected area by March 21, 2016. How other staff having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. A full audit of all facility sprinkler heads was conducted on March 15, and 16, 2016 for placement, operation and cleanliness for function. Any sprinkler heads found to be deficient were replaced by March 21, 2016. Systemic changes made to ensure that the deficient practice does not recur included a one-on-one re-education of the Maintenance Director in regards to sprinkler placement, operation and cleanliness for function by March 16, 2016. In addition, the maintenance director/designee will perform an audit of facility sprinkler heads monthly for 3 months to ensure placement, operation and cleanliness. How the corrective actions will be monitored is the results of the audit will be reviewed monthly for 3 months at the QAPI meeting by the interdisciplinary team. Completion Date: March 21, 2016</p> <p>K 069 The corrective action accomplished for those staff/visitors found to have been affected by the deficient practice was the installation of an enclosed</p>	03/21/2016	

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	<p>states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect five staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facilities during a tour of the facility from 9:20 a.m. to 1:00 p.m. on 03/07/16, one of four designated locations underneath the kitchen range hood system drip trays was missing an enclosed metal container for grease to drain into. The designated location for the missing grease container had three one inch in diameter holes in the drip tray beneath the system filters but no container was present. Based on interview at the time of observation, the Director of Facilities acknowledged one of four designated locations underneath the kitchen range hood system drip trays</p>		<p>metal container for grease to drain into underneath the kitchenrange hood system drip trays by March 21, 2016. How other staff/visitors having the potential to be affectedby the same deficient practice will be identified and what corrective actionswill be taken. A full audit of the metalcontainers for grease to drain into underneath the kitchen range hood systemdrip trays was conducted on March 15, 2016 for placement, operation andcleanliness for function. Any metalcontainers found to be deficient were replaced by March 21, 2016. Systemic changes made to ensure that the deficient practicedoes not recur included one-on-one re-education of the Maintenance Director inregards to metal container placement, operation and cleanliness for function by March 16, 2016. In addition, the maintenance director/designee will audit facility metal containers monthly for 3 months to ensureplacement, operation and cleanliness. How the corrective actions will be monitored is the results of the audit will bereviewed monthly for 3 months at the QAPI meeting by the interdisciplinary team. Completion Date: March 21, 2016</p>				

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

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	was missing an enclosed metal container for grease to drain into.  3.1-19(b)				