

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155404	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2014
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NAME OF PROVIDER OR SUPPLIER  ESSEX NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 301 W ESSEX ST LEBANON, IN 46052
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K010000	<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: 09/18/14</p> <p>Facility Number: 000291 Provider Number: 155404 AIM Number: 100286710</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Essex Nursing and Rehabilitation 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 one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and spaces open to the corridors. Resident rooms are</p>	K010000		

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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K010038 SS=F	<p>equipped with battery powered smoke detectors. The facility has the capacity for 38 residents and had a census of 31 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has four detached equipment storage buildings which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without</p>	K010038	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</p> <p><b><u>K - 038</u></b></p>	10/18/2014			

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	<p>delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects all visitors and residents.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 09/18/14 between 11:30 a.m. and 3:00 p.m., all emergency exit doors were magnetically locked. The maintenance director demonstrated the locks would release by entering a code into the keypad adjacent to the door frame, and again when the fire alarm activated on 09/18/14 at 2:15 p.m. The code was not posted. The maintenance director said at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated but there had been a resident "who could read the code and get out", so the posted codes were removed.</p> <p>3.1-19(b)</p>		<p>-</p> <p><b>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</b></p> <p>Instructions have been posted at each door on the egress side that will allow visitors and cognitively intact residents to readily unlock the doors at all times.</p> <p><b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b></p> <p>All cognitively intact residents and visitors could have been affected.</p> <p><b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b></p> <p>Instructions have been posted at each door on the egress side that will allow visitors and cognitively intact residents to</p>		

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K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1		<p>readily unlock the doors at all times.</p> <p><b>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and Maintenance Director. The Maintenance Director will ensure that the instructions are posted at least weekly and a Report of findings will be discussed at the monthly Risk Management/QA meeting to ensure compliance has been met.</p> <p><b>(E) Date Certain:</b></p> <p>10-18-2014</p>	

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	<p>Based on record review and interview, the facility failed to provide a written fire safety plan addressing all items required by NFPA 101 - 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director and administrator on 09/18/14 at 2:50 p.m., required elements of the policy and procedure for the written Fire Plan were missing or found in different and separate places. Two documents were located in the disaster manual available to staff for training and direction in the event of fire: Emergency Fire Procedures and,</p>	K010048	<p><b>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</b></p> <p><b><u>K -048</u></b></p> <p>-</p> <p><b>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</b></p> <p>A new comprehensive fire policy has been written and enacted that follows the R.A.C.E. model. The policy also encompasses the relocation of residents and the different types of extinguishers for different types of fires.</p> <p><b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b></p> <p>All residents have the</p>	10/18/2014			

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	Emergency Procedures. The Emergency Fire Procedure directed staff to: 1. remain calm, 2. contain the fire by smothering or if too large and safety permits, use a fire extinguisher to put out the fire, 3. remove residents from immediate area, 4. close the door, 5. turn in alarm, place door knob hanger on door after the room is checked and door closed, refer to disaster preparedness procedure for further instructions. The Emergency Procedures policy offered as further evidence of the fire plan provided instruction for extinguishing a fire with the note under General: "It is the response to the first few minutes of a fire that determine the boundary line between containment and catastrophe....." The remainder of the document directed staff to extinguish various fires. Both procedures failed to address the evacuation of residents to another smoke compartment, the immediate evacuation of residents in a fire area as the first action with the activation of an alarm to summon help. Emergency Procedures stated, "Use fire extinguisher if unable to extinguish by smothering. Both mentioned all fire extinguishers in the facility may be used on any type of fire. There was no mention of the K class extinguisher, it's location and special instructions for use in relationship with the use of the kitchen hood extinguishing system. The		potential to be affected.  <b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b>  The Maintenance Director will Inservice all staff on the new policy and Procedure prior to 10-18-2014 All newly hired staff will be instructed on the fire policy during facility orientation.  <b>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</b>  The Maintenance Director will perform Monthly fire drills testing staff response as part of the fire prevention program. A Report of findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.	

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K010062 SS=E	<p>administrator acknowledged at the time of record review, staff were not trained fire fighters, the procedures were incomplete and unclear and the response sequence for each should have addressed the evacuation of residents before any fire fighting was attempted.</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 a storage room sprinkler head in 1 of 3 smoke compartments was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 10 or more residents in the back smoke compartment.</p> <p>Findings include:</p>	K010062	<p><b>(E) Date Certain:</b></p> <p>10-18-2014</p> <p><b>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</b></p> <p><b><u>K -062</u></b></p> <p>-</p> <p><b>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</b></p>	10/18/2014	

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	<p>Based on observation with the maintenance director on 09/18/14 at 1:05 p.m., the storage on shelves in the "new storage closet" in Restroom C was located eight inches from the only sprinkler head providing protection for the area. The maintenance director acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p>		<p>The items have been removed to maintain the appropriate clearance in the storage closet.</p> <p><b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b></p> <p>All residents have the potential to be affected.</p> <p><b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b></p> <p>The Maintenance Director will perform Monthly inspections of sprinkler head clearance on all the facility sprinkler heads.</p> <p><b>(D)How the corrective action(s) will be monitored to</b></p>		

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K010144 SS=F	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. 1. Based on observation, interview and record review; the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy	K010144	<b>ensure the practice will not recur:</b>  The Maintenance Director will perform Monthly inspections of sprinkler head clearance. A Report of findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met  <b>(E) Date Certain:</b>  10-18-2014  <b>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law. <u>K-144</u></b> <b>(A)What corrective action(s)</b>	10/18/2014	

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	<p>sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure</p> <p>b) Liquefied petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> <li>3. A statement that there is a low probability of interruption of the natural gas.</li> <li>4. A brief description that supports the statement regarding the low probability</li> </ol>		<p><b>will be accomplished for those residents found to have been affected:</b> The facility located the Statement of reasonable reliability of natural gas delivery from Vectren dated 8/5/2005. In addition a new Statement was obtained from Vectren dated 9/19/2014. Safecare returned the document to the facility on 9/19/2014 showing that the generator had been moved and that a level 1 diagnostic test had been completed. This test meets the requirements for the battery testing. <b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b> All residents have the potential to be affected.</p> <p><b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b> The facility located the Statement of reasonable reliability of natural gas delivery from Vectren dated 8/5/2005. In addition a new Statement was obtained from Vectren dated 9/19/2014. A copy of the Statement has been placed in the Life Safety book and a copy is in each of the Fire and Disaster Manuals. The generator testing is part of our preventive maintenance program.</p> <p><b>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</b> The Maintenance</p>	

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	<p>of interruption,</p> <p>5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/18/14 at 2:15 p.m., the emergency generator was fueled by natural gas. Preventive maintenance and other emergency generator records reviewed on 09/18/14 at 2:55 p.m. with the administrator and maintenance director, did not include a letter from the natural gas vendor which assured the reliability of the fuel supply. The administrator said at the time of record review, he would have to contact the vendor for the documentation.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and</p>		<p>Director will insure that there is a copy of the statement in each fire and disaster book and life safety book with each update of the manuals. The Maintenance director will complete weekly generator tests and A report of findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.</p> <p><b>(E) Date Certain:</b> 10-18-2014</p>		

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K010147	<p>Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Weekly Generator check, with the maintenance director on 09/18/14 at 2:15 p.m., the last documentation of weekly battery inspections for the emergency generator was dated 08/15/14. The maintenance director said at the time of record review, he had documented his weekly checks but a contractor must have taken the more recent records so he had no more current documentation.</p> <p>3.1-19(b) NFPA 101</p>			

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SS=E	<p><b>LIFE SAFETY CODE STANDARD</b> Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure the policy for extension cord use and a flexible cord was not used as a substitute for fixed wiring in 1 of 3 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/18/14 at 12:40 p.m., a power strip extension cord was located under the foot of the resident's bed in room 18 to power the television and other electrical equipment. A Fire Safety Rules policy was reviewed with the maintenance director on 09/18/14 at 2:15 p.m. which noted "Do not use extension cords". The maintenance director acknowledged at the time of record review, the power strip extension cord should not have been in use.</p>	K010147	<p><b>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is being submitted in good faith by the facility because it is the law.</b></p> <p><b><u>K-147</u></b></p> <p>-</p> <p><b>(A)What corrective action(s) will be accomplished for those residents found to have been affected:</b></p> <p>Room 18 will be hardwired with a new two gang outlet. The facility will not use hospital grade 15amp circuit breaker power strips to power any medical equipment.</p> <p><b>(B)How will you identify other residents having potential to be affected and what corrective action will be taken:</b></p>	10/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155404	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2014
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	3.1-19(b)		<p>All other resident rooms have been checked to ensure that there is no medical equipment on a hospital grade 15amp circuit breaker power strip. No power strips were being used to power medical equipment.</p> <p><b>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur:</b></p> <p>If additional outlets are required to power electrical equipment a new two gang wired outlet will be installed.</p> <p><b>(D)How the corrective action(s) will be monitored to ensure the practice will not recur:</b></p> <p>The Maintenance Director will insure that there are no power strips being used to power any medical equipment. Additionally if more outlets are required the Maintenance Director will install a two gang outlet. A report of findings will be</p>	

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			discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.  <b>(E) Date Certain:</b>  10-18-2014		