

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/26/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/26/2015</p> <p>Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530</p> <p>At this Life Safety Code survey, Signature Healthcare of Bremen 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms 301-309. Battery powered smoke alarms</p>	K 0000	The facility requests that this plan of correction be considered its credible allegation of compliance for the survey conducted on October 26, 2015. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is submitted timely and in accordance with State and Federal Regulatory Guidelines.	

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 0018 SS=B Bldg. 01	<p>were located in resident rooms 101-124, and in resident rooms 201-216. The facility has the capacity for 97 and had a census of 63 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered, all areas providing facility services were sprinklered.</p> <p>Quality Review completed 10/29/15 - DA</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 1¼ 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 regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 49 resident room doors closed and latched into the door frame. This deficient practice could affect any of the 16 residents on the 100 hall.</p>	K 0018	It is the intent of this facility to ensure that all resident room doors properly close and latch into the frame.1. The door to room 122 was repaired by maintenance by adjusting the striker plate.2. All doors	11/25/2015

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K 0025 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 10/26/15 at 12:01 p.m., the corridor door to resident room 122 failed to latch into the door frame. Based on interview at the time of observation, this was acknowledged by the Plant Operations Director.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 6 smoke barrier walls were protected to maintain</p>	K 0025	<p>throughout the facility were checked to ensure that all close and latch properly.3. Maintenance director has increased the number and frequency of doors being checked and recorded weekly. All staff were inserviced regarding reporting to maintenance any doors found to be improperly latching to his department immediately utilizing the work orders.4. Maintenance director will report to QAPI committee tracking and trending of any issues related to doors closing and latching monthly for the next 3 months and quarterly thereafter until the team determines that 100 % compliance is being consistently met.</p> <p>It is the intent of this facility to ensure the penetrations caused by the passage of wire and/or conduit are protected to maintain the smoke resistance of each smoke barrier.1. All identified</p>	11/25/2015

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	<p>the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 50 residents in 5 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Plant Operations Director on 10/26/15 between 1:00 p.m. and 2:00 p.m., the following smoke barrier walls had unsealed penetrations or penetrations filled with an un-approved material:</p> <p>a) above the ceiling tiles of the service hall smoke barrier wall there were five unsealed half inch penetrations around pipes.</p> <p>b) in the attic of the service hall smoke barrier wall there was an unsealed three inch pipe sleeve filled with yellow insulation.</p> <p>c) above the ceiling tiles of the smoke</p>		<p>areas were caulked with fireproof caulking.2. Maintenance director and/or designee will complete rounds to include areas above the drop ceiling including all smoke barrier walls and ensure that no other areas of penetration exist.3. Maintenance director and/or designee will fill all identified areas of penetration with fireproof caulk and replace any loose or missing putty to ensure all potential hazardous areas have been closed off.4. Maintenance director/designee will report to QAPI committee monthly for 3 months, and quarterly thereafter any further issues with putty/caulk found missing or causing a penetration violation, until the committee feels that 100% compliance is being consistently achieved.</p>	

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	<p>barrier wall by room 103 there was a twelve by five inch opening containing pipes, the opening was filled with yellow insulation around the pipes.</p> <p>d.) in the attic of the serenity hall smoke barrier wall there were three unsealed three inch pipe sleeve filled with yellow insulation.</p> <p>f) above the ceiling tiles of the south smoke barrier wall by room 302 there were five unsealed half inch penetrations around a wire and plastic tubing. Based on interview at the time of observation, the Plant Operations Director acknowledged and provided the measurements of the penetrations. Also, the Plant Operations Director acknowledged the yellow insulation was an un-approved material for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 28 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p>			

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K 0029 SS=E Bldg. 01	<p>Based on observations during a tour of the facility with Plant Operations Director on 10/26/15 at between 10:20 a.m. and 1:55 p.m., the following ceiling smoke barrier had unsealed penetrations:</p> <p>a) in the ceiling of the human resources closet there were two unsealed fourth of an inch penetrations around conduit.</p> <p>b) in the ceiling of the janitors closet in the serenity dining room there was an unsealed fourth of an inch penetration around a pipe.</p> <p>Based on interview at the time of observation, the Plant Operations Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are</p>			

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	<p>permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 5 hazardous areas, such as a kitchen, a boiler room, fuel-fired heater room and room exceeding 50 square feet containing combustible material, was smoke resistive. This deficient practice could affect 40 residents in 3 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 10/26/15 between 10:45 a.m. and 12:55 p.m., the following hazardous areas had unsealed penetrations:</p> <p>a) in the main mechanical room, which contained a fuel-fired boiler, there was an unsealed half inch penetration around the vent for the boiler.</p> <p>b) in the south mechanical room, which contained a fuel-fired boiler hot water heater, there were five unsealed fourth of an inch penetrations around pipes.</p> <p>c) in the maintenance room, a room exceeding 50 square feet containing combustible material, there were two unsealed fourth of an inch penetrations around heater supports and an unsealed two inch by one inch hole in the ceiling.</p> <p>d) the serving door to the kitchen from the assisted dining room was not</p>	K 0029	<p>It is the intent of this facility to ensure in any of the hazardous areas, such as the kitchen, boiler room, etc. that all areas remain smoke resistive. 1. All identified areas were caulked with fire barrier sealant. 2. Maintenance director and/or designee will complete rounds to include areas above the drop ceiling including all smoke barrier walls and ensure that no other areas of penetration exist. 3. Maintenance director and/or designee will fill all identified areas of penetration with fireproof caulk and replace any loose or missing putty to ensure all potential hazardous areas have been closed off. 4. Maintenance director/designee will report to QAPI committee monthly for 3 months, and quarterly thereafter any further issues with putty/caulk found missing or causing a penetration violation, until the committee feels that 100% compliance is being consistently achieved.</p>	11/25/2015			

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K 0038 SS=E Bldg. 01	<p>equipped with a self closing device. Based on interview at the time of observation, the Plant Operations Director acknowledged and the serving door was not equipped with a self closer.</p> <p>3.1-19(b)</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 1 of 9 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " This deficient practice could affect 11 residents in the therapy room.</p> <p>Findings include:</p>	K 0038	<p>It is the intent of this facility to ensure that the signage for exit doors be clearly labeled.1. The decorations were removed from the door in the therapy area.2. Maintenance director checked all other doors to ensure nothing was obstructing the instructions for release of the delayed egress locking doors.3. Maintenance director will add to weekly preventative maintenance rounds to check all doors of egress to ensure instructions have not been covered up or removed.4. Maintenance director or designee will present to QAPI monthly the results of the PM and trend any areas/issues identified. The director will include these results for the next 3 months and quarterly thereafter until the committee feels that 100%</p>	11/25/2015

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K 0046 SS=C Bldg. 01	<p>Based on observations during the tour of the facility with the Plant Operations Director on 10/26/15 at 12:34 p.m., the exit door from the therapy room to the courtyard was equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked proper signage regarding pushing the door to open. There was a sign posted, but the sign was faded and was not readable, also there was a decoration taped to the door covering part of the sign. Based on interview at the time of observation, the Plant Operations Director acknowledged the sign was not readable and covered with a decoration.</p> <p>3.1-15(b)</p> <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 observation, and interview; the facility failed to ensure emergency light fixtures for 1 of 1 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and</p>	K 0046	<p>compliance is consistently being maintained.</p> <p>It is the intent of this facility to ensure that emergency light fixture for the generator is tested properly.1. There were no residents affected by this citation.2. The Maintenance director/designee will ensure that the emergency fixture for the generator is tested in accordance with the latest standard.3. The Maintenance director has updated the PM book to included emergency battery powered lights are tested 30 seconds monthly</p>	11/25/2015

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K 0048 SS=F Bldg. 01	<p>every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. 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 occupants.</p> <p>Findings include:</p> <p>Based on record review with the Plant Operations Director on 10/26/15 at 10:00 a.m., no documentation was available for review to show the testing of the emergency battery powered lights at the facility's generator. Based on interview at the time of record review, when ask if the emergency battery powered lights are tested 30 seconds monthly and 90 minutes annually; the Plant Operations Director stated the emergency battery powered lights are tested for 15 seconds monthly, and no 90 minutes annual test is conducted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the</p>		<p>and 90 minutes annually to ensure adequate testing and documentation is occurring.4. The Maintenance director/designee will report to QAPI committee monthly for 3 months and quarterly thereafter to ensure testing and documentation are being completed until the committee feels that consistent compliance is being met.</p>				

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	<p>event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. 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"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on a record review of the "Fire Discovery and Announcement" with Plant Operations Director on 10/26/15 at 10:23 a.m., the plan did not address response to the activation of a resident room battery operated smoke detector. Based on interview, this was acknowledged by the Plant Operations Director at the time of record review.</p>	K 0048	<p>It is the intent of this facility to have a comprehensive written plan related to response to fire safety equipment including battery operated smoke detectors.1. There were no residents negatively affected, as no battery operated smoke detectors have been activated.2. All battery operated smoke detectors have been identified throughout the building and will continue to be monitored via the preventative maintenance program in place.3. The policy and procedure was updated to include the procedures to follow upon the activation of a resident room battery operated smoke detector, and staff were educated on the policy change and on the expected response if a battery operated smoke detector were to activate. 4. The maintenance director/designee will report to the QAPI committee any identified issues related to the battery operated smoke detectors for the next three months and quarterly thereafter until the committee determines that consistent compliance has been established.</p>	11/16/2015

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K 0067 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 100% of fire dampers within the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on Plant Operations Director on 10/26/15 at 10:00</p>	K 0067	<p>It is the intent of this facility to ensure that all fire dampers are inspected and that necessary maintenance is provided.1. There were no residents adversely affected.2. All required inspections were reviewed to ensure that no others had been missed.3. The maintenance director has developed a spreadsheet to include all required mechanical testings and will review monthly with the CEO to ensure that all required inspections are being completed timely.4. The maintenance director/designee will report to QAPI committee monthly all inspections completed as well as any issues identified with plans to address the issues to ensure continued compliance. This will remain an ongoing monthly report.</p>	11/25/2015

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K 0075 SS=E Bldg. 01	<p>a.m., there were no inspection records available for review for any of the facility's fire dampers. Based on interview during records review; the Plant Operations Director stated a damper inspection was conducted, but there were no records available to show completed maintenance on the facility's fire dampers.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to properly maintain 2 of 2 unattended trash and soiled linen collection receptacles with a capacity of more than 32 gallons within a 64 square foot area, located in a hallway. This deficient practice affects up to 13 residents in the serenity hall.</p> <p>Findings include:</p>	K 0075	<p>It is the intent of this facility to properly maintain soiled linen and trash receptacles throughout the facility.1. There were no residents affected.2. Daily rounds are being made to ensure any receptacles in the hallways are kept at least 8 feet apart from each other.3. Staff were educated regarding the placement of receptacles in the hallways and areas other than the hallways have been identified for staff to store containers.4. Maintenance director/designee</p>	11/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/26/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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K 0130 SS=C Bldg. 01	<p>Based on observation during the tour of the facility with the Plant Operations Director on 10/26/15 at 12:22 p.m., two mobile collection receptacles stood side by side in the serenity hallway. One receptacle was marked "trash" and the second receptacle was marked "soiled linen" and both combined were greater than 32 gallons. Based on interview at the time of observation, the Plant Operations Director acknowledged the capacity of the two collection receptacles exceeded 32 gallons and then moved the receptacles more than eight feet apart.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 40 of 49 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. LSC 9.6 states a fire alarm shall be installed, tested, and maintained to NFPA 72, National Fire Alarm Code. This deficient practice affects all occupants of the facility.</p>	K 0130	<p>will make rounds and report to QAPI monthly for the next 3 months to ensure staff continue to properly store soiled linen and trash recepticals.</p> <p>It is the intent of this facility to implement and maintain a preventative maintenance program for battery operated smoke detectors.1. There were no residents affected.2. All battery powered smoke detectors were identified throughout the entire building so that a PM document could be created.3. The Maintenance director will include in monthly PM a check of a minimum of 1/4 of all battery operated smoke detectors to ensure all are checked per the manufacturer's recommendations.4. Maintenance</p>	11/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/26/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506		
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	<p>Findings include:</p> <p>Based on records review of the "Smoke Detector Monthly Check List on TELS" with the Plant Operations Director on 10/26/15 at 10:33 a.m., there was no indication that the battery operated smoke alarms located in the residents' rooms were cleaned according to manufacturer's cleaning recommendations. Based on an interview during records review, the Plant Operations Director stated the manufacturer's cleaning recommendations was unknown. Also, the Director of Maintenance confirmed 40 resident rooms were equipped with a battery operated smoke alarms and was unable to provide any documentation to show cleaning was conducted since the alarms were installed more than a year from 10/26/15.</p> <p>3.1-19(b)</p>		<p>director/designee will report to QAPI monthly any identified issues/replacements for those battery operated smoke detectors checked during the month. This will continue to be a monthly standing report to the committee.</p>		