

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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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
K0000	<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: 01/23/13</p> <p>Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Providence Home Health Care 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 two story facility with a basement was determined to be of</p>	K0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective February 22, 2013 to the state findings of the Life Safety Code Recertification survey conducted on January 23, 2013.	

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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	<p>Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 53 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 the elevator equipment room, one detached garage used for facility storage, a generator building, and a greenhouse.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system which provided complete coverage in 1 of 7 smoke compartments. This deficient practice could affect all residents, staff and visitors while in the basement which includes the laundry room, maintenance shop, beauty shop, and auditorium which could seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 01/23/13 at 11:00 a.m. during a tour of the facility with the Environmental Director and the Maintenance Director, the elevator</p>	K0056	The corrective action taken for those residents found to be affected by the deficient practice is that no residents were identified as being affected. The corrective action taken for other residents having the potential to be affected by the same deficient practice is that a local fire and safety contractor was contacted about the installation of a sprinkler system in the elevator equipment room. The measures or systemic changes that have been put in place to ensure the deficient practice does not recur is that a sprinkler system was installed in the elevator equipment room per NFPA-13 requirements for hydraulic elevators. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that the sprinkler	02/22/2013			

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	<p>equipment room in the basement was not provided with sprinkler coverage. This was acknowledged by the Environmental Director and the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>system installed in the elevator equipment room will be inspected quarterly by a contractor certified in sprinkler system installation and maintenance as part of the quarterly overall inspection of the sprinkler system. The environmental services director will report the outcomes of the quarterly inspections at the quarterly Quality Assurance Committee meetings to determine if additional action is warranted.</p>		