

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
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NAME OF PROVIDER OR SUPPLIER CORE OF DALE	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF ROAD DALE, IN 47523
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K 0000 Bldg. 02	<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: 01/05/16</p> <p>Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490</p> <p>At this Life Safety Code survey, Core of Dale 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 44 at the time of this</p>	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or of conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state law. This Plan of Correction is submitted in order to respond to the allegations of noncompliance during complaint survey review concluding on 02/05/2016. Please accept this Plan of Correction as the provider's credible aggregation of compliance effective on 01/05/2016. We respectfully request a desk review for compliance.	

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 0029 SS=E Bldg. 02	<p>survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached laundry building.</p> <p>Quality Review completed on 01/08/16 - DA</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 permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous area room doors, such as a room over 50 square feet containing combustible material, was equipped with a self closing device on the door. This deficient practice could affect up to 26 residents, as well as staff and visitors while in the west wing.</p>	K 0029	<p>K-0029</p> <p>It is the policy of CORE to assure safety to all residents, staff, family and visitors and remain in compliance with all State and federal regulations pertaining to doors and gates. Hazardous Areas with combustible contents are to be equipped with automatic or self-closing devices/doors and will be installed and functioning properly.</p>	02/04/2016			

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K 0038 SS=E Bldg. 02	<p>Findings include:</p> <p>Based on observation on 01/05/16 at 12:15 p.m. during a tour of the facility with the Environmental Director, the corridor door to the west wing Supply Room was not provided with a self closing device. This room was over fifty square feet and contained combustible material such as shelves full of adult diaper packages, cardboard boxes, plastic and other items. This was acknowledged by the Environmental Director at the time of observation.</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>1. Based on observation and interview, the facility failed to ensure 1 of 1 exterior gates from the west wing exit fenced in area, swung in the direction of egress travel. LSC 7.2.1.4.3 states a door shall swing in the direction of egress travel. This deficient practice could affect up to 26 residents, as well as staff and visitors while exiting the west wing through the west wing exit.</p> <p>Findings include:</p>	K 0038	<p>All residents, staff, visitors, family and vendors could have been affected by this alleged deficient practice.</p> <p>Systemic changes are that the door to this Hazardous storage area has been replaced with an automatic door closure system.</p> <p>It will be the Environmental Supervisors responsibility to perform audits 5 times a week for 1 month then 3 times a week for one month then weekly for at least 1 year to assure that all like areas are equipped with automatic door closure system and are functioning properly with results forwarded to QA committee quarterly.</p> <p>K 038 It is the policy of CORE Nursing to assure safety to all residents, staff, family and visitors and remain in compliance with State and Federal Regulations pertaining to Exit Access and Egress of Doors and exit doors and gates. And four digit codes to magnetic key pad lock is posted nearby.</p> <p>This alleged deficiency could have affected 26 residents, staff and other visitors on the west unit.</p> <p>Systemic changes are that the West Unit Exit Gate has been</p>	02/04/2016			

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	<p>Based on observation on 01/05/16 at 12:30 p.m. during a tour of the facility with the Environmental Director, the west wing outside exit gate swung into the fenced in area instead of swinging in the direction of egress to the parking lot outside the gate. This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 locked emergency exit gate was readily accessible for residents and visitors. This deficient practice could affect up to 26 residents, as well as staff and visitors while exiting the west wing through the west wing exit.</p> <p>Findings include:</p> <p>Based on observation on 01/05/16 12:30 p.m. during a tour of the facility with the Environmental Director, the gate outside the west wing exit was provided with a magnetic lock which required a four digit code on the adjacent keypad or activation of the fire alarm system to release. The code to unlock the magnetic lock was not posted near the gate. This was acknowledged by the Environmental</p>		<p>maintenancedand reversed so that egress issue resolved and is compliant with all regulationspertaining to Exit Access. Code has nowbeen posted near this exit gate.</p> <p>It will be the Environmental Supervisors responsibility tocomplete these maintenance compliance issues. And continue with her regularbuilding inspection rounds monthly to assure compliance and function of theExit.</p>		

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K 0048 SS=F Bldg. 02	<p>Director at the time of observation.</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 event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 44 of 44 residents to accurately address all life safety systems such as staff response to battery operated smoke alarms in resident sleeping rooms, plus a system 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"> (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 occupants in the event of an emergency.</p> <p>Findings include:</p>	K 0048	K 048 It is the policy of CORE Nursing to Protect all residents, staff and visitors from death or injury by providing a written plan for smoke detector, alarms and evacuation plan in the event of an emergency. All residents, staff and visitors had the potential to be affected by this alleged deficient practice. Systemic changes are that a policy and procedures for smoke detector alarms be included into the fire safety policy. By in-servicing and re-education of all staff of these additional procedures will now be implemented for full compliance of this regulation. It is the Environmental Supervisors responsibility to assure in-servicing completed for all staff and that random audits pertaining to smoke detector alarms be incorporated into monthly fire alarm audits.	02/04/2016			

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K 0050 SS=C Bldg. 02	<p>Based on a review of the fire plan in the Disaster Manual on 01/05/16 at 10:45 a.m. with the Environmental Director present, the fire plan did not address staff response to battery operated smoke alarms in all resident sleeping rooms. Based on interview at the time of record review, the Environmental Director acknowledged the fire plan did not include staff response to battery operated smoke alarms in all resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>	K 0050	K 050 It is the policy of CORE Nursing that the staff is familiar with procedures and is aware that drills are a part of the regular established routines. All residents in the facility could have been affected by this alleged deficient practice. Systemic Changes are that Fire drills are held at unexpected times and under	02/18/2016

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K 0144 SS=C Bldg. 02	<p>Based on review of the facility's fire drills on 01/05/16 at 9:15 a.m. with the Environmental Director present, three of four third shift (night) fire drills were performed between 5:26 a.m. and 6:12 a.m. During an interview at the time of record review, the Environmental Director acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>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.</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test, furthermore, the facility failed to provide documentation that the transfer time for the generator was being recorded. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5</p>			K 0144	<p>varying conditions at least quarterly for all three shifts. And also between 9pm and 6am it is now policy to have silent alarms with written verification of drills from Vanguard Alarm Company to be kept in fire drilllogs. It will be the responsibility of the Administrator to audit fire drill logs monthly for a year to assure that drills are performed at varied times and that written documentation of silent alarms are logged per policy.</p> <p>It is the policy of CORE Nursing that generator(s) are inspected weekly and exercised under load for 30 minutes per month per Regulation and that all inspection data logged with date and times. All residents, staff and visitors could have been affected by this alleged deficient practice. Systemic Changes were made to</p> <p>1. Log forms to include cool down times of 5 minutes and will be included in documentation with weekly and monthly inspection and testing of generator. 2. That the generator be exercised under operating temperature conditions (or at not less than 30%EPS) for a minimum of not less than 30</p>		02/04/2016

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	<p>minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's emergency Generator Log on 01/05/16 at 9:25 a.m. with the Environmental Director present, the generator log form documented the generator was tested weekly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test, furthermore, there was no documentation that showed the generator transfer time being recorded. During an interview at the time of record review, the Environmental Director confirmed the monthly generator log did not include documentation of a cool down time being recorded or the generator transfer time being recorded.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview,</p>		<p>minutes during a 12 month period and that dates and times are documented on log sheets. 3. Documentation will be completed weekly on all inspection of hoses, water, fuel, belts, batteries, blocker heater and exercise. It will be the responsibility of the Administrator to do weekly audits of documentations for 2 months, then monthly audits of all related documentation for the completion of a year.</p>				

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	<p>the facility failed to provide complete documentation for the testing of 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 monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. 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 could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's emergency Generator Log on 01/05/16 at 9:25 a.m. with the Environmental Director present, the generator log form documented the generator was tested monthly under load, however, the documentation did not show the</p>			

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	<p>generator was exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months. This was acknowledged by the Environmental Director at the time of record review, furthermore, the Environmental Director stated the emergency generator was a diesel generator and there was no load bank test documentation available.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for 1 of 1 emergency generators was available for 49 of 52 weeks. NFPA 99, 3-4.4.1.3 requires storage batteries used in connection with essential electrical 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. Furthermore, NFPA 110, 6-3.6 requires storage batteries, including electrolyte levels, be inspected at intervals of not more than 7 days. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSSs, including all</p>			

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	<p>appurtenant components, shall be inspected weekly. NFPA 99, 3-4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's emergency Generator Log on 01/05/16 at 9:30 a.m. with the Environmental Director present, there was weekly generator documentation available to show the generator was started, however, there was no documentation to show visual inspections of the generators oil, water, fuel, hoses, belts, battery, blocker heater, and exercise except for three weeks during the past twelve months. Based on interview at the time of record review, the Environmental Director confirmed there was no documentation to show visual inspections of the generators oil, water, fuel, hoses, belts, battery, blocker heater, and exercise except for three weeks during the past twelve months.</p> <p>3.1-19(b)</p>			

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K 0147 SS=D Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 maintain an electric outlet in 1 of 24 resident sleeping rooms. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect two residents in room 106.</p> <p>Findings include:</p> <p>Based on observation on 01/05/16 at 12:00 p.m. during a tour of the facility with the Environmental Director, the electric outlet for the AC/heat wall unit was missing the cover or faceplate. This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0147	<p>K 147 It is the policy of CORE Nursing to maintain electrical outlets in resident sleeping rooms to have no live parts exposed, and if so be secured by cover or faceplates. Two residents were potentially affected by this alleged deficient practice. Systemic Changes made were to replace the missing faceplate to room 106. It will be the Environmental Supervisors responsibility to audit all sleeping rooms cover or faceplates weekly times 3 months then monthly thereafter for a total of 1 year with results being forwarded to QA Committee Quarterly for recommendations or suggestions.</p>	02/04/2016	