

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 09/30/2014
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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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K010000	<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: 09/30/2014</p> <p>Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530</p> <p>Surveyor: Brett Overmyer, Life Safety Code Specialist</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</p>	K010000	<p>Please accept this Plan of Correction as the Credible Allegation for the survey conducted on September 30, 2014. Submission of this plan of correction is not an admission by Signature Healthcare of Bremen that the deficiencies alleged in the survey are accurate or depict the quality of nursing care and services provided the residents of this health care facility. This plan of correction is submitted timely and in accordance with State and Federal Regulatory Guidelines. We respectfully request Desk Review of the Plan of Correction for this survey completed on September 30, 2014.</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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K010050 SS=F	<p>the corridors, and resident rooms 301-309. Battery powered smoke alarms 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 74 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 by Dennis Austill, Life Safety Code Specialist on 10/07/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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</p>			

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K010062 SS=B	<p>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 interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor between 09:15 a.m. and 11:30 a.m., on 09/30/14, the following was noted:</p> <p>a) A fire drill was not documented for the second shift of the second quarter of 2014.</p> <p>b) A fire drill was not documented for the first shift of the third quarter of 2014.</p> <p>Additionally, per interview during the review, the Maintenance Supervisor acknowledged there was no other documentation available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K010050	<p>CORRECTIVE ACTION:The facility now uses a computerized system that generates the information for performing required Fire Drills. This reminds the facility of the time frame and the shift the Fire Drill should be conducted.HOW OTHERS IDENTIFIED:Implementation of this computerized system will address all residents.PREVENTATIVE MEASURES:The implementation of the computerized system will prevent further occurrence.MONITORING:Reminders are sent to the Maintenance Director to ensure that the Fire Drills are conducted in the required time frame and on appropriate shifts. Fire Drills will be reviewed monthly by Maintenance Director and/or designee during QAPI process to ensure they are completed appropriately. This monitoring will occur until 95% compliance is reached with all Fire Drills.Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.</p>	10/01/2014	

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	<p>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 clearance of at least 18 inches was maintained below the level of the sprinkler deflector for 1 of 1 sprinklers in the kitchen freezer storage room and 1 of 1 sprinklers in the receptionist office closet / storage room. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.2 says a continuous or noncontinuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice affects at least ten residents, staff and visitors throughout the facility.</p> <p>Finding include:</p> <p>Based on observation between 12:30 p.m. and 2:30 p.m. on 09/30/2014, with the Maintenance Supervisor, the following was noted:</p> <p>a) the minimum 18 inch clearance below the sprinkler head deflector was not provided in the kitchen freezer storage room. The room contained boxes and other items stacked all around the room which were within 18 inches of the sprinkler head deflector.</p> <p>b) the minimum 18 inch clearance below</p>	K010062	<p>CORRECTIVE ACTION:The items that were cited in the survey have been removed.</p> <p>HOW OTHERS IDENTIFIED:Correcting this citation will address all residents.PREVENTATIVE MEASURES:A line indicating the 18 in" clearance has been marked in the kitchen freezer storage area as well as the receptionist office storage area to indicate no items can be stored that would be beyond this mark.MONITORING:Maintenance Director and/or Designee will monitor these areas to prevent further occurrence. These areas will be monitored 3 times per week for 4 weeks, then weekly for 4 weeks, and then monthly for 4 months. All findings will be reviewed monthly at QAPI. When compliance of 95% is reached the monitoring will be discontinued.</p>	10/13/2014

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K010144 SS=C	<p>the sprinkler head deflector was not provided in the receptionist office closet / storage room. There were boxes placed on a wooden shelf that provided 8 inches of clearance.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned conditions.</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>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator remote manual stop was properly identified. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building and properly identified.</p> <p>A-3-5.5.6 states, for Level 1 and Level 2</p>	K010144	<p>CORRECTIVE ACTION:The remote stop for the generator has been marked by a sign to indicate purpose.HOW OTHERS IDENTIFIED:Marking the purpose of this remote manual stop will address the issue for all residents.PRVENTATIVE MEASURES:The posting of the sign will be monitored to ensure that it is in place.MONITORING:The posting of the sign will be monitored by Maintenance Director and/or Designee weekly for 6 months. All findings will be reviewed monthly at QAPI. When compliance of 95% is reached the monitoring will be discontinued.Any deficient practice will be addressed with re-education, in-servicing, and/or</p>	10/13/2014

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	<p>systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation and interview between 12:30 p.m. and 2:30 p.m. on 09/30/14, the Maintenance Supervisor acknowledged, a remote manual stop was positioned on the brick wall just outside of the exit door from the sprinkler room but was not labeled to identify that this was the remote manual stop for the emergency generator.</p> <p>3.1-19(b)</p>		counseling.		