STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(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
K010000	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). Survey Date: 07/21/14 Facility Number: 000465 Provider Number: 155501 AIM Number: 100273870 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Signature Healthcare of Bluffton 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. 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 smoke detection in the corridors and in areas open to the corridors with battery operated smoke	K010000	K000000 The facility requests that this plan of correction beconsidered its credible allegation of compliance. Preparation and/or execution of this plan ofcorrection does not constitute admission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement of thedeficiencies. The plan of correction isprepared and/or executed solely because of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	detectors in the resident rooms. The facility has a capacity of 120 and had a census of 51 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the maintenance office, maintenance supplies and tools that was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/22/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	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 1¾ 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			

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	Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 1 of 57 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 1 of 8 smoke compartments. Findings include: Based on observation with the Plant Operations Director on 07/21/14 at 2:12 p.m., the corridor door to resident room 610 failed to latch into the door frame. Based on an interview with the Plant Operations Director at the time of observation, he worked on the door a few weeks ago. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 3 of 8 Reflection's unit resident rooms corridor doors. This deficient practice could affect 1 of 8 smoke compartments. Findings include: Based on observations with the Plant Operations Director on 07/21/14 at 11:58	K010018	K 018 It is the intent of this facility to maintain doors thatlatch into the door frame. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Residents residing in the 600hallway have the potential to be affected. This facility has ordered a new doorfor room 610 that will be installed upon delivery. The Maintenance Director hasremoved storage items in the closed reflections unit to ensure all doors willlatch into the door frames. In addition the corridor of the closed Reflection'sunit has been cleared. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to DepartmentManagers regarding storage in the closed unit, by the CEO, with regards to therequirements of the regulations of doors latching into the frame and blockageof corridor. 1.How the corrective action (s)	08/30/2014

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	a.m., the corridor doors to three of eight resident rooms in the Reflection's unit were obstructed by furniture, beds and general storage preventing the doors from closing and latching into the door frame. The Reflection's unit is currently closed to resident access and the resident rooms are being used for storage. Additionally, office supplies, tools and various other miscellaneous items are stored in the corridor of the Reflection's unit. This was acknowledged by the Director of Plant Operations at the time of observations. 3.1-19(b)		will be monitored to ensure the deficient practice will not recur; Maintenance Director will monitortracking log weekly x 3 weeks; monthly x2 and then quarterly thereafter toensure compliance and will report findings to the Performance ImprovementCommittee monthly until substantial (100%) compliance achieved. 1.CEO responsible to ensure compliance by 8/30/2014.	
K010029 SS=E	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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 5 water heater rooms, a hazardous area, was self closing and latched into the	K010029	K 029 It is the intent of this facility to maintain doors thatlatch into the door frame. 1.What corrective action(s) will	08/30/2014

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	door frame. This deficient practice could affect 1 of 8 smoke compartments. Findings include: Based on an observation with the Plant Operations Director on 07/21/14 at 2:35 p.m., the corridor door to the water heater room near resident room 505 did self close but it failed to latch into the door frame. This was acknowledged by the Plant Operations Director at the time of observation. 3.1-19(b)		be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential tobe affected. The Maintenance Director has repaired the door latch and adjustedthe door to ensure the ability to self-close and latch into the door frame. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to MaintenanceDepartment regarding water heater rooms and rooms containing hazardous materials,by the CEO, with regards to the requirements of the regulations of self-closingdoors and latching into the frame. 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Maintenance Director will monitortracking log weekly x 3 weeks; monthly x2 and then quarterly thereafter toensure compliance and will report findings to the Performance ImprovementCommittee monthly until substantial (100%) compliance achieved. 1.CEO responsible to ensure	

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			compliance by 8/30/2014.	
K010048 SS=C	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 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 shall provide for the following: (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 This deficient practice could affect all residents. Findings include: Based on a record review with Plant Operations Director on 07/21/14 at 1:58 p.m., the "Disaster Preparedness Fire Plan" manual did not address the activation of a resident room battery	K010048	K 048 It is the intent of this facility to maintain policies andprocedures to ensure resident safety. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential tobe affected. The facility has incorporated a policy for battery operated smokedetectors. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to all staffregarding battery operated smoke detectors, by the SDC and MaintenanceSupervisor, with regards to the requirements of the regulations for use,transmission of alarm to fire department, response, isolation of fire,evacuation of immediate area, evacuation of smoke department, preparation ofbuilding for evacuation, and	08/30/2014

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	operated smoke detector. This was acknowledged by the Plant Operations Director at the time of record review. 3.1-19(b)		extinguishment of fire. 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Maintenance Director will conductfire alarms monthly, alternating on each shift ensuring every shift has atleast one fire drill on a quarterly basis. 1.CEO responsible to ensure compliance by 8/30/2014.	
K010050 SS=F	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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire/Disaster Drill Report" with the Plant Operations Director on 07/21/14 at 12:22 p.m., there was no record of a third shift fire drill for	K010050	K 050 It is the intent of this facility to conduct fire drills accordingto federal and state regulations. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential tobe affected. Maintenance Director will	08/30/2014

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	the fourth quarter of 2013. Based on an interview with the Plants Operations Director at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)		conduct fire drill on at least a monthlybasis alternating shifts ensuring that every shift has at least one fire drilleach quarter. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to MaintenanceDirector regarding monthly fire drill requirements 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Maintenance Director will documenton tracking log monthly. CEO will monitor x 3 months; quarterly thereafter toensure compliance and will report findings to the Performance ImprovementCommittee monthly until substantial (100%) compliance achieved. 1.CEO responsible to ensure compliance by 8/30/2014.	
K010067 SS=F	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 Based on record review and interview, the facility failed to ensure all dampers in the ventilation system were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air	K010067	K 067 It is the intent of this facility to ensure that allrequired inspections are completed timely. 1.What corrective action(s) will be accomplished for those residents found to have been	08/30/2014

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	conditioning, heating, ventilating ductwork 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 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 could affect all occupants. Findings include: Based on an interview with the Plant Operations Director on 07/21/12 during the record review process at 1:20 p.m., he knew there were dampers in the ventilation system but was unable to provide documentation of an inspection prior to his arrival to the facility in December 2013. 3.1-19(b)		affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential tobe affected. Facility has contactedlicensed contractor to inspect all dampers. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; Education has been provided to MaintenanceSupervisor regarding inspection requirements and frequency. 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; Maintenance Director and CEO will reviewrequired inspections quarterly to ensure compliance. 1.CEO responsible to ensure compliance by 8/30/2014.	
K010144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD			

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	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on review of the generator log titled "Monthly Log Sheet" with the Plant Operations Director on 07/21/14 at 12:45 p.m., the March and May 2014 documentation for the monthly generator	K010144	K 144 It is the intent of this facility to maintain generator logsto include amp usage to ensure compliance. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential tobe affected. The Maintenance Director will beusing automated system that automatically calculates amps for each phaseensuring that percentage load operating from generator can be verified. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur; The Maintenance Director will beusing automated system that automatically calculates amps for each phaseensuring that percentage load operating from generator can be verified. 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; CEO will monitor tracking logweekly	08/30/2014

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	load test did not include the amps for each phase of the generator so the percentage of the load could not be verified. This was acknowledged by the Plant Operations Director at the time of record review. 3.1-19(b)		x 3 weeks; monthly x2 and then quarterly thereafter to ensure complianceand will report findings to the Performance Improvement Committee monthly untilsubstantial (100%) compliance achieved. 1.CEO responsible to ensure compliance by 8/30/2014.	
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient care area but could affect facility staff in the nursing office. Findings include: Based on observations with the Plant Operations Director on 07/21/14 at 11:55 a.m., a microwave was plugged into an extension cord power strip in the Business Manager Office. This was	K010147	K 147 It is the intent of this facility to ensure safety ofresidents and stakeholders. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; No residents have the potential tobe affected. The Maintenance Director immediatelyrelocated the microwave and plugged directly into an outlet. In addition, hedid a sweep of entire building with no other negative findings. 1.What measures will be put into place or what systematic changes will be made to ensure	08/30/2014

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	acknowledged by the Plant Operations Director at the time of observation. 3.1-19(b)		that the deficient practice will not recur; Education has been provided to all staffby the SDC and Maintenance Supervisor, regarding power equipment with a highcurrent draw being plugged directly into an outlet and use of power stripsaccording to regulations. 1.How the corrective action (s) will be monitored to ensure the deficient practice will not recur; CEO will monitor tracking logweekly x 3 weeks; monthly x2 and then quarterly thereafter to ensure complianceand will report findings to the Performance Improvement Committee monthly untilsubstantial (100%) compliance achieved. 1.CEO responsible to ensure compliance by 8/30/2014.	