STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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: 11/19/14 Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Newburgh Health Care 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 (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	K010000	Preparation and or execution of this Plan of Correction general or any other corrective action set forth herein, in particular,does not constitute an admission by Newburgh Healthcare of the facts alleged or the conslusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed soley because of provisions of State and Federal 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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	rooms. The facility has a capacity of 114 and had a census of 104 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage, were sprinklered, except a small detached wood framed shed used for furniture storage and a walk in cooler outside the kitchen service hall exit. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
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			

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	permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 2 of 3 shower rooms which contained soiled linen containers and trash containers with a total capacity over 32 gallons, were equipped with self closing devices on the doors. This deficient practice could affect any number of residents, as well as staff and visitors while in and around the west and east shower rooms. Findings include: Based on observations on 11/19/14 between 11:45 a.m. and 1:15 p.m. during a tour of the facility with the Environmental Supervisor, the east and west shower room doors were not equipped with self closing devices. The east shower room had one soiled linen container and one trash container with a total capacity of over 32 gallons partial to half full, furthermore, the west shower room had one soiled linen container, and two trash containers with a capacity of over 32 gallons partial to half full. This was acknowledged by the Environmental Supervisor at the time of each observation, furthermore, when asked, the Environmental Supervisor said the soiled linen and trash containers were normally stored in the shower rooms.	K010029	**Corrective Action** 1. All shower room doors will be equipped with self – closing devices. 2. The Central Supply Room Door now has a self – closing device. **Others Having the Potential to Be Affected** All residents, staff, and visitors on the East, West, and North Units have the potential to be affected. **Measures and Systemic Changes** The Maintenance Department will install door closures by 12/19/14. **Monitoring** The Maintenance Department will monitor the door closures monthly. This monitor will be ongoing. A summary will be submitted at the next quarterly Quality Assurance Performance Improvement meeting. Any areas of concern will be submitted thereafter.	12/19/2014

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	3.1-19(b) 2. 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 13 residents, as well as staff and visitors in the west unit. Findings include: Based on observation on 11/19/14 at 12:15 p.m. during a tour of the facility with the Environmental Supervisor, the corridor door to the Central Supply room was not provided with a self closing device. This room was over fifty square feet and contained combustible material such as cardboard boxes, paper, plastic and other items. This was acknowledged by the Environmental Supervisor at the time of observation. 3.1-19(b)			
K010038 SS=E	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 Based on observation and interview, the	K010038	**Corrective Action**	12/19/2014

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	facility failed to ensure 2 of 10 exit access doors which were equipped with delayed egress locks and were provided with signs stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS did open when pushing on the door for 15 seconds. 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be		1. Vanguard Alarm Company were contacted have tested all egress locking devices adjusting as needed. 2. The egress lock on the left exit door by the West Nurse's Station will be replaced and has been ordered from the Code Alert Alarm Company. 3. The single exit door lock was adjusted by Vanguard. **Others Having the Potential to Be Affected** All residents, visitors, and staff on the West and North Units have the potential to be affected. **Measures and Systemic Changes** 1. Vanguard Alarm Company were contacted have tested all egress locking devices adjusting as needed. 2. The egress lock on the left exit door by the West Nurse's Station will be replaced and has been ordered from the Code Alert Alarm Company. The single exit door lock was adjusted by Vanguard.	

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	required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing 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 stroke 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 up to 53 residents in the West Unit of the facility. Findings include: Based on observations on 11/19/14 between 11:45 a.m. and 1:15 p.m. during a tour of the facility with Environmental Supervisor, the following was noted: 1. The left side door of the set of exit doors near the west unit Nurses' Station was equipped with a delayed egress lock and was provided with a sign stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, however, when the door was		**Monitoring** The Maintenance Department will check door alarms on a monthly basis. This monitor is ongoing. A summary will be submitted at the next quarterly Quality Assurance Performance Improvement Committee meeting. Any areas of concern will be submitted thereafter.	

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	pushed several times for 15 seconds it did not release. It did however release when the five digit code was pushed as well as when the fire alarm system was tested. 2. The single exit door next to the Housekeeping Office was equipped with a delayed egress lock and was provided with a sign stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, however, it took 40 seconds each time to release the door when tested twice. It did however release immediately when the five digit code was pushed as well as when the fire alarm system was tested. This was acknowledged by Environmental Supervisor at the time of each observation. 3.1-19(b)			
K010048 SS=F	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 104 of 104 residents to accurately address all life safety systems such as, the use of the K-class fire extinguisher in the kitchen, evacuation of the smoke compartment, and staff response to	K010048	**Corrective Action** The Fire Evacuation Procedure will be revised to include all 8 requirements specific to NFPA101, 2000 edition, Section 19.7.2.2 LSC 19.7.2.2 **Others Having the Potential to Be Affected** All residents, staff, and visitors have the potential to be affected. **Measures and**	12/19/2014

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	battery operated smoke detectors 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: (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 occupants in the event of an emergency. Findings include: Based on a review of the Fire Procedure on 11/19/14 at 10:45 a.m. with the Environmental Supervisor present, the Fire Procedure did not address the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, staff response to battery operated smoke detectors in resident sleeping rooms, and the evacuation of the smoke compartment. Furthermore, R.A.C.E. was addressed and the "E" for Extinguish		**Systemic Changes** 1. The evacuation plan, use of the K-class fire extinguisher, evacuation of the smoke compartment and smoke detectors will be reviewed and revised by the Staff Development Coordinator. 2. Facility Staff will be in serviced on the changes to the policy. **Monitoring** The above procedures will be monitored for compliance with each fire drill by the Staff Development Coordinator or designee. A summary will be submitted in each quarterly Quality Assurance Performance Improvement Committee meeting. Any areas of concern will be submitted thereafter and staff in serviced appropriately. This monitor is ongoing.	

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	stated "If fire is small, extinguish or smother it". Based on interview at the time of record review, the Environmental Supervisor acknowledged the Fire Procedure was not a complete and accurate plan. 3.1-19(b)			
K010050 SS=C	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 held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire Drill book on 11/19/14 at 11:30 a.m. with the Environmental Supervisor present, the following was noted: 1. Eight of ten second shift (evening) fire	K010050	**Corrective Action** The Fire Drill Policy will be revised to ensure that times for the drills are varied throughout the day. **Others Having the Potential to Be Affected** All residents, staff and visitors have the potential to be affected.	12/19/2014

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	drills were performed between 2:30 p.m. and 3:30 p.m. 2. Ten of twelve third shift (night) fire drills were performed between 5:20 a.m. and 5:50 a.m. During an interview at the time of record review, the Environmental Supervisor acknowledged the times the second and third shift fire drills were performed and agreed the times were not varied enough. 3-1.19(b)		**Measures and Systemic Changes** The Staff Development Coordinator or Designee will conduct fire drills at various times of the day, evening, and night shifts and document monthly. **Monitoring** The Staff Development Coordinator will monitor and forward the reports to the facility Administrator monthly. Reports will be included in the quarterly Quality Assurance Performance Improvement Committee meetings. This monitor is ongoing.	