STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155768	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE PROTESTANT HOME INC	3701 WASHINGTON AVE EVANSVILLE, IN 47714

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K020000	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: 03/26/14 Facility Number: 001125 Provider Number: 155768 AIM Number: NA Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Evansville Protestant Home, Inc. was found not in compliance with Requirements for Participation in Medicare, 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 facility consists of two buildings connected by a service corridor. The north building is a one story facility with a basement determined to be of Type II (000) and fully sprinklered. The south building is a one story facility determined to be of Type II (000) and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 54 at the time of this survey. All areas where the residents have	K020000	Life Safety Code plan of correction is respectfully submitted to the Indiana State Department of Health. The preparation and or execution of this plan of correction or any other correction set forth herein does not constitute an admission or agreement by the Evansville Protestant Home of the facts alleged or in conclusions set forth in the statement of deficiencies. The plan of correction and specific actions are solely executed for provisions 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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	customary access were sprinklered. All areas providing facility services were sprinklered except one detached wood framed storage shed. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/31/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K020040 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 Based observation and interview, the facility failed to ensure sleeping room exit doors provided at least 32 inches in clear width for 26 of 59 resident sleeping rooms. This deficient practice could affect 25 residents in the North Unit. Findings include: Based on observation on 03/26/14 between 9:30 a.m. and 12:15 p.m. during a tour of the facility with the Environmental Director, the following resident sleeping room door openings in the North Unit measured only 31 and 1/4 inches: Rooms 1 through 18, 20, 22, 24, 25, 26, 27, 29, and 30. This was confirmed by the Environmental Director who measured the door openings. 3.1-19(b)	K020040	Annual Waiver Request Provider # 155768 See attachments for additional information.	04/25/2014
K020046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD			

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	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review, observation and interview; the facility failed to ensure the documentation for the testing of 17 of 17 battery powered light sets was complete when testing monthly for 30 seconds. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the battery lights information in Vanguard binder on 03/26/14 at 2:15 p.m. with the Environmental Director and Maintenance Tech # 1 present, there was no documentation to show the seventeen battery back up light sets throughout the facility were tested monthly for at least thirty seconds during the past twelve months. This was confirmed by Environmental Director at the time of record review. Based on observation between 9:30 a.m. and 12:15 p.m. during a tour of the facility with the Environmental Director, all seventeen battery back up light sets worked properly.	K020046	Environmental Service Director has implemented new preventive maintenance record for the completion of monthly 30 second test regarding emergency lights located throughout the facility. The test shall be done monthly by environmental service director or designee and documented on preventive maintenance record. Environmental Services staff has been in-serviced regarding preventive maintenance completion and record keeping of additional duties.	04/25/2014

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K020048 SS=F	3-1.19(b) 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 54 of 54 residents to accurately address all life safety systems such as the evacuation of the smoke compartment and the use of all types of fire extinguishers in the facility including the K-class fire extinguisher in the kitchen thus 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 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 Plan section of the Emergency Manual on 03/26/14 at 1:30 p.m. with the Environmental Director and Maintenance Tech # 1 present, the Fire Plan did not address the evacuation of the smoke	K020048	The RACE method for responding to a fire emergency has been updated to include the following: The **R.A.C.E.** method for responding to a fire emergency: ***R -*** *Rescue* Move patients and assist visitors or impaired employees away from immediate danger of fire or smoke IF YOU CAN DO THIS WITHOUT PUTTING YOURSELF IN IMMEDIATE DANGER and IF THERE ARE OTHER STAFF AVAILABLE TO COMMUNICATE THE EMERGENCY AND PULL THE ALARM. ***A***- *Alert others* Activate manual pull station alarm as soon as possible. Call 911 and state the location, type of fire and size. Notify co-workers using "page" feature on phones - and make sure everybody in the area, and in other departments in your area, know as well. ***C***- *Confine* Close all doors and windows. Pack sheets and towels under doors to contain smoke. Ensure fire doors are also closed to create additional fire/smoke barriers from the fire. If there is oxygen in the area: Oxygen to a resident can be shut off by a nurse at the bedside after other staff have the resident in a safe area and are	04/25/2014

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	compartment, the types of fire extinguishers used in the facility including the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, R.A.C.E. was addressed in the Fire Plan and the "A" for Alarm stated "Turn on Alarm" with no further explanation or mention of how to activate the alarm via fire alarm pull stations, also, the "C" for Confine stated "Confine the Fire" with no further explanation of how to confine the fire. Based on interview at the time of record review, the Environmental Director acknowledged the Fire Plan was not a complete and accurate plan. 3.1-19(b)		ventilating them. ***E***- *Extinguish* Select the appropriate fire extinguisher. All hall accessible fire extinguishers in the facility are ABC class fire extinguishers and use the P-A-S-S technique to extinguisher the fire. (see below for P-A-S-S technique) **ABC class** extinguishers are multipurpose and can be used for (but not limited too)trash, wood, paper, liquid, grease and electrical equipment. **K-Class** Extinguisher is kept in dietary department only and is a wet chemical fire extinguisher to be used **after** the Kitchen Suppression system (HOOD) activates. The HOOD can be activated by pulling the pin to the suppression system but is designed to activate with heat sensors automatically. **PASS** procedures: This is how to properly operate a fire extinguisher. **1.P**ull the pin, release a lock latch, or press a puncture lever. **2.A**im the extinguisher nozzle, horn, or nose at the base of the fire. **3.S**queeze or press the handle. **4.S**weep from side-to-side in most cases. But extinguishing techniques vary. Read the directions. ***E***- *Evacuate* Move people (residents, visitors, staff) to next fire/smoke compartment in the facility. Stay in the evacuation area until ordered to move by the Administrator or Fire Department.	

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			Close all doors behind you. If you are not at the scene of the fire, make sure you can hear page instructions and the 'all clear'. Have someone posted near a phone to relay this information. LISTEN for the "All Clear" announcement or further instructions. All staff shall receive in-service education regarding the updated emergency preparedness policy, specifically the RACE system. The new emergency preparedness information shall be placed in the emergency preparedness manuals throughout the facility for reference as needed.	
K020050 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 3 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	K020050	Fire drill times have been reviewed with the environmental services director and shall be completed per regulatory requirement of rotating shifts and various times. An annual fire drill flow sheet has been implemented to clearly identify month, shift and time. The Environmental Services Director is responsible for ensuring varied times are	04/25/2014

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	Book on 03/26/14 at 1:00 p.m. with the Environmental Director and Maintenance Tech # 1 present, three of four first shift (day) fire drills were performed between 9:43 a.m. and 10:40 a.m., three of four second shift (evening) fire drills were performed between 3:58 p.m. and 4:04 p.m., and three of four third shift (night) fire drills were performed between 3:56 a.m. and 5:00 a.m. During an interview at the time of record review, the Environmental Director acknowledged the times when the first, second and third shift fire drills were performed and agreed the times were not varied enough.		used and shall audit the times and provide quarterly report to Quality Assurance Committee for tracking purposes. Any discrepancies shall be corrected immediately.	
K020144 SS=C	3-1.19(b) 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.			
	Based on record review and interview, the facility failed to provide complete documentation for the testing of 2 of 2 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 conditions or 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	K020144	Vanguard performed the annual load test on 4-10-14 with no issues noted. Generator Load test will continue to be performed. To enhance currently compliant operations the facility has modified the generator log to indicate percentage. In the box "run under load" which environmental services was indicating with a yes or no, the box has been changed to "% run under load". Generator log in-service education has been completed with the environmental service staff who will be responsible for completing the generator log on a weekly basis.	04/25/2014

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	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. Findings include: Based on review of the facility's Emergency Generator Log on 03/26/14 at 2:00 p.m. with the Environmental Director and Maintenance Tech # 1 present, the generator log form documented the generator was tested weekly under load, however, there was no documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months. The generator log form was provided with a box for "Run Under Load", with the word "Yes" documented during each weekly load test. Furthermore, the most recent load bank test for this diesel generator was during June of 2012. During an interview at the time of record review, the Environmental Director acknowledged the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes. 3.1-19(b)			