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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 03/14/2016 |
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| NAME OF PROVIDER OR SUPPLIER PRESENCE SACRED HEART HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710 |
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| K 0000 Bldg. 01 | <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: 03/14/2016</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>At this Life Safety Code survey, Presence Sacred Heart Home 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) and 410 IAC 16.2. The original building consisting of the St. Anthony, St. Claire, St. Paul, and the St. Frances neighborhoods as well as the main dining room, chapel and service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the</p> | K 0000 | Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provided legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance. We are requesting a paper compliance audit. | |
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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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| K 0011 SS=F Bldg. 01 | <p>corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 112 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with exception of the elevator equipment room.</p> <p>Quality Review completed on 03/17/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire barriers to nonconforming buildings were protected by a two hour fire wall. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> | K 0011 | Shawnee construction completed the addition to the firewall which separates the health care building from the independent living building of drywall to the roof decking fill the one foot gap, see picture The Maintenance Supervisor inspected all other fire walls and found no gaps or penetrations to the roof deck, all are in compliance. The | 03/23/2016 |

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| K 0029 SS=E Bldg. 01 | <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 2:10 p.m., the firewall located in the front waiting area which separates the health care building from the Independent Living building was not complete. Above the ceiling tiles and behind the insulation, the fire wall was constructed out of brick and cement block but stopped one foot short of the steel corrugated roof. The one foot gap ran down the length of the fire wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the fire wall stopped one foot short of the roof.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 corridor</p> | K 0029 | <p>Maintenance Supervisor is responsible for conducting a quarterly visual inspection of all fire walls for the next 12 months and on-going and is responsible to report findings to QA team quarterly. Maintenance Supervisor responsible, QA Team to monitor.</p> <p>The Bio-Hazard utility room door in the "E" Hall Snyder's Lock & Key removed the old self-close</p> | 04/12/2016 | | | |

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| | <p>doors to the Bio-Hazard utility room, a hazardous area, was provided with self-closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 22 residents in "E" hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 1:20 p.m., the Bio-Hazard utility room door in "E" hall was not equipped with a self-close device. The Bio-Hazard utility room contained barrels of hazardous waste, a can of plastic waste, and a large cart filled with four trash bags containing garbage. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen double doors automatically closed and latched into the door frame. This deficient practice was not in a resident care area but could affect all staff in the service hall and in the kitchen.</p> <p>Findings include:</p> | | <p>device and installed a new self-close devise, see picture The kitchen double doors Snyder's Lock & Key to replace both automatic door closures and replaced the latch with a new latching mechanism, see picture Maintenance Supervisor completed an inspection of all other self-close devices and found them all to be in compliance. Maintenance Supervisor will conduct a monthly inspection using Environmental Checklist #15 for the next 12 months to ensure all self-close devices are operating properly and the doors close and latch into the door frame, Maintenance Supervisor to report findings to the QA Team on a monthly basis for the next 12 months Maintenance Supervisor responsible, QA Team to monitor for 12 months</p> | | |

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| K 0038 SS=C Bldg. 01 | <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 1:24 p.m., there was a set of double doors entering the kitchen from the service hall. The first of the double doors was not self-closing, and was equipped with a manual slide latch that latched into the frame. The second door was self-closing and latched automatically into the first door. Based on interview, this was acknowledged by the Maintenance Supervisor 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>Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the basement was provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a twostep</p> | K 0038 | Snyder's Lock & key removed the dead bolt lock and installed a new blank cover, see picture Maintenance Supervisor inspected all other exit doors and all were in compliance. | 03/14/2016 |

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| K 0056 SS=F Bldg. 01 | <p>release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Maintenance Supervisor on 03/14/16 at 10:33 a.m., the basement door which led to the outside and was marked as an exit was equipped with an independent dead bolt in addition to the door knob. Based on interview, the Maintenance Supervisor acknowledged the basement door had an independent dead bolt at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific</p> | | | | | | |

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| | <p>areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 elevator equipment rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. The elevator equipment rooms was located in the basement and could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 11:02 a.m., the basement elevator equipment room lacked sprinkler coverage with a shunt trip or a suppression system. Based on interview at the time of observation, the</p> | K 0056 | In the elevator equipment room Snyder's Lock and Key to remove non fire rated door and install a new 2 hour rated fire door. The sprinkler will be re-installed to provide sprinkler coverage and a shunt-trip of the electrical supply will be installed. The Maintenance Supervisor is responsible and will monitor | 04/12/2016 |

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| K 0062 SS=F Bldg. 01 | <p>Maintenance Supervisor stated there use to be a sprinkler head in the elevator equipment room but the state elevator inspector made the facility take it out. It was unknown by the Maintenance Supervisor if the room was ever equipped with a shunt trip.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure sprinkler water-flow alarm devices were tested quarterly for 2 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of "Report of Sprinkler Inspection" documentation from Simplex Grinnell with Maintenance Supervisor on</p> | K 0062 | <p>Regarding the sprinkler inspection where the water-flowalarms are to be tested quarterly Simplex completed this test on 3-25-16 Regarding the automatic sprinkler piping systeminspection to be inspected every 5 years Simplex completed this inspection on3-25-16. Regarding testing the sprinkler gauges on the dry systemevery 5 years Simplex completed the test/ inspection on 3-25-26 , see attached Maintenance Supervisor responsible to maintain a calendarlog of all inspections that are due to ensure compliance. Maintenance Supervisor to monitor monthlyfor the next 12 months and report findings to the QA Team for 12 months Maintenance Supervisor</p> | 03/25/2016 | | | |

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| | <p>03/14/16 at 10:00 a.m., the facility lacked documentation of a sprinkler inspection where the water-flow alarms were tested for the second and third quarter of 2015. Based on an interview at the time of record review, the Maintenance Supervisor was unable to provide any documentation for a 2015 second and third quarter inspection.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 2 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/16/16 at 10:05 a.m., no documentation was available to show a five year internal pipe inspection was conducted. Based on an interview at the time of record review, Maintenance Supervisor did provide a service agreement from Simplex Grinnell 02/19/16 stating a five year inspection should be completed "ASAP", but no</p> | | responsible, QA Team to monitor for 12 months | | | | |

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| | <p>other documentation was available for review to show an internal pipe inspection was completed in the last five years.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler gauges on the dry system were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 11:10 a.m., the sprinkler gauges of the sprinkler riser on "H" hall had dates of 2010. Based on an interview at the time of observation, the Maintenance Supervisor did provide a service agreement from Simplex Grinnell on 02/19/16 stating four sprinkler gauges should be replaced "ASAP", but was unable to verify if the sprinkler gauges had been calibrated or replaced.</p> | | | |

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| K 0069 SS=E Bldg. 01 | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 2 of 2 hood extinguishing systems in the both kitchens was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect up to 35 residents in the Saint Paul dining room and the kitchen staff.</p> <p>Findings include:</p> <p>Based on record review of the "Range Hood Suppression Report" by Simplex Grinnell with Maintenance supervisor on 03/14/16 at 10:03 a.m., the last inspection date for the main kitchen and Saint Paul kitchen suppression system was 07/09/2015. The facility was unable to provide documentation to confirm the hood extinguishing system received a semiannual inspection after the Simplex Grinnell inspection date 07/09/2015. Based on interview during record review, the Maintenance Supervisor acknowledge</p> | K 0069 | Simplex completed the range hood semi-annual inspection on 3-8-16, see attached Maintenance Supervisor responsible to maintain a calendar log of all inspections that are due to ensure compliance. Maintenance Supervisor to monitor monthly for the next 12 months and report findings to the QA Team for 12 months Maintenance Supervisor responsible, QA Team to monitor for 12 months | 03/25/2016 | | | |

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| K 0073 SS=E Bldg. 01 | <p>the paperwork stated the last inspection was conducted on 07/09/2015.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4</p> <p>Based on observation, the facility failed to ensure 1 of 1 gift shops remain free of combustible decorations. This deficient practice affects up to 10 residents in the "The Corner Shop."</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 12:40 p.m., there were nine unlit candles with a wick in "The Corner Shop." Based on interview at the time of observation, the Maintenance Supervisor acknowledged there were nine candles with a wick and could not remove the candle at that time without permission.</p> <p>3.1-19(b)</p> | K 0073 | <p>Simplex completed the range hood semi-annual inspection on 3-25-16 Maintenance Supervisor responsible to maintain a calendar log of all inspections that are due to ensure compliance. Maintenance Supervisor to monitor monthly for the next 12 months and report findings to the QA Team for 12 months Maintenance Supervisor responsible, QA Team to monitor for the next 12 months</p> | 03/14/2016 |

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| K 0130 SS=E Bldg. 01 | <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is</p> | K 0130 | <p>Maintenance Supervisor repaired the one inch penetration with Hilte Fire rated caulk, see pictures</p> <p>Maintenance Supervisor conducted an inspection of all other fire wall barriers to ensure there were no penetrations, all were in compliance. Maintenance Supervisor responsible to monitor monthly using Environmental Checklist #21 for the next 12 months and report findings to the QA team for the next 12 months</p> | 03/16/2016 |

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| K 0143 SS=E Bldg. 01 | <p>capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect up to 15 residents in the front lobby.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/15/16 at 1:50 p.m., there was an unsealed one inch penetration around a pipe in the fire wall to the convent. Based on interview at the time of observation, the Maintenance Supervisor confirmed the wall was a fire barrier and provided measurements of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete</p> | | | | | | |

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| K 0147 SS=D Bldg. 01 | <p>flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice was not in a patient treatment area but could affect any staff in the service hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 1:38 p.m., the mechanical ventilation system was not working were transferring of oxygen took place in the oxygen storage room on the service hall. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the oxygen room mechanical vent was not working.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> | K 0143 | Maintenance Supervisor repaired the exhaust fan on 3-16-16, see picture. Maintenance Supervisor responsible to monitor weekly to ensure proper operation using Environmental Checklist #18 and to report findings monthly to the QA Team for the next 12 months and on-going. | 03/16/2016 | |

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| K 0000 Bldg. 03 | <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 could affect 2 resident in room B-6.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 10:45 a.m., in room B-6, a regular light weight extension cord was plugged into a power strip extension cord providing power for a fan. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by</p> | K 0147 | Maintenance Supervisor removed the light weight extension cord and replaced it with an approved hospital grade power strip. Maintenance Supervisor responsible to monitor monthly to ensure light weight extension cords are not used. Maintenance supervisor using Environmental Checklist #23 to report findings on a monthly basis to the QA Team for the next 12 months and on-going. | 03/14/2016 | |
| | | K 0000 | Submission of this plan of correction and credible allegation | | |

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| | <p>the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/14/2016</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>At this Life Safety Code survey, Presence Sacred Heart Home 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) and 410 IAC 16.2. The new section of the building consisting of the H wing was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 112 at the time of this survey.</p> <p>All areas where the residents have</p> | | <p>of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provided legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance. We are requesting a paper compliance audit.</p> | | | | |

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| K 0011 SS=F Bldg. 03 | <p>customary access were sprinklered and all areas providing facility services were sprinklered with exception of the elevator equipment room.</p> <p>Quality Review completed on 03/17/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire barriers to nonconforming buildings were protected by a two hour fire wall. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 2:10 p.m., the firewall located in the front waiting area which separates the health care building from the Independent Living building was not complete. Above the ceiling tiles and behind the insulation, the fire wall was</p> | K 0011 | <p>Shawnee construction completed the addition to the firewall which separates the health care building from the independent living building of drywall to the roof decking fill the one foot gap, see picture The Maintenance Supervisor inspected all other fire walls and found no gaps or penetrations to the roof deck, all are in compliance. The Maintenance Supervisor is responsible for conducting a quarterly visual inspection of all fire walls for the next 12 months and on-going and is responsible to report findings to QA team quarterly. Maintenance Supervisor responsible, QA Team to monitor.</p> | 03/23/2016 |

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| K 0062 SS=F Bldg. 03 | <p>constructed out of brick and cement block but stopped one foot short of the steal corrugated roof. The one foot gap ran down the length of the fire wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the fire wall stopped one foot short of the roof.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure sprinkler water-flow alarm devices were tested quarterly for 2 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of "Report of Sprinkler Inspection" documentation from Simplex</p> | K 0062 | <p>Regarding the sprinkler inspection where the water-flowalarms are to be tested quarterly Simplex completed this test on 3-25-16 Regarding the automatic sprinkler piping systeminspection to be inspected every 5 years Simplex completed this inspection on3-25-16. Regarding testing the sprinkler gauges on the dry systemevery 5 years Simplex completed the test/ inspection on 3-25-26 , see attached Maintenance Supervisor responsible to maintain a calendarlog of all inspections that are due to ensure compliance. Maintenance Supervisor to monitor monthlyfor the next 12 months and report findings to the QA Team for 12 months Maintenance Supervisor</p> | 03/25/2016 |

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| | <p>Grinnell with Maintenance Supervisor on 03/14/16 at 10:00 a.m., the facility lacked documentation of a sprinkler inspection where the water-flow alarms were tested for the second and third quarter of 2015. Based on an interview at the time of record review, the Maintenance Supervisor was unable to provide any documentation for a 2015 second and third quarter inspection.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 2 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/16/16 at 10:05 a.m., no documentation was available to show a five year internal pipe inspection was conducted. Based on an interview at the time of record review, Maintenance Supervisor did provide a service agreement from Simplex Grinnell 02/19/16 stating a five year inspection</p> | | responsible, QA Team to monitor for 12 months | | | | |

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| | <p>should be completed "ASAP", but no other documentation was available for review to show an internal pipe inspection was completed in the last five years.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler gauges on the dry system were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/14/16 at 11:10 a.m., the sprinkler gauges of the sprinkler riser on "H" hall had dates of 2010. Based on an interview at the time of observation, the Maintenance Supervisor did provide a service agreement from Simplex Grinnell on 02/19/16 stating four sprinkler gauges should be replaced "ASAP", but was unable to verify if the sprinkler gauges had been calibrated or replaced.</p> | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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