

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155701	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/21/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 720 E DUSTMAN RD BLUFFTON, IN46714
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K0000	<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: 12/21/11</p> <p>Facility Number: 000576 Provider Number: 155701 AIM Number: 100267760</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Christian Care Retirement Community 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 two story facility was determined to be of Type II (111)</p>	K0000	<p>This letter and Plan of Correction serve as our Allegation of Compliance that as of January 9, 2012, Christian Care Retirement Community has corrected the sited deficiencies and has implemented all of the systemic changes to comply with State and Federal Regulations except for the following two requests:</p> <p>First, we are requesting an extension of time that is less than 90 days for the K 029 deficiency. The reason for the extension of time is related to the delivery time for the new latching doors.</p> <p>Second, we are submitting an IDR to have the K 056 deficiency removed. We have included our supporting documentation.</p> <p>Please let us know if these requests will be granted. Thank you for your consideration.</p>	

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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K0017 SS=E	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 66 and had a census of 63 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/29/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and</p>	K0017	What corrective action(s) will be accomplished for those residents	01/03/2012	

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	<p>interview, the facility failed to ensure 1 of 1 health care reception areas was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect all residents near the health care reception area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 12/21/11 at 11:40 a.m., the health care reception area was not</p>		<p>found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> · Smoke detector for healthcare reception area was installed by US Automatic Fire & Security on 1/3/12 (see Appendix A for work order) <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> · The building has been inspected and all other Healthcare reception areas have a smoke detector <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> · If any new remodel projects occur, a thorough evaluation will occur to determine if a smoke detector is needed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> · The Safety Committee and the Quality Assurance Committee will review all remodel projects going forward to ensure that safety issues have been 		

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K0029 SS=E	<p>separated from the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the reception area was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 kitchens, a hazardous area, latched into the door frame. This deficient practice could affect residents near the kitchen</p> <p>Findings include:</p>	K0029	<p>addressed</p> <p>By what date the systemic changes will be completed.</p> <p>1/3/12</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A project quote from Lin's Lock and Keys has been received to install latching door and push bar openers for the kitchen doors (Appendix B). The quote was received on 1/6/12 with estimated delivery time of up to 6 weeks. Therefore, the project is</p>	02/17/2012	

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	<p>Based on an observation with the Maintenance Director and the Maintenance Assistant on 12/21/11 at 11:19 a.m., the double corridor doors entering the kitchen lacked latching hardware and did not latch into the door frame. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>scheduled to be completed by 2/17/12.</p> <ul style="list-style-type: none"> Christian Care is asking for an extension of time to correct this deficiency because of the delivery time. Christian Care has notified staff of the project to install a latch in order to increase fire safety awareness related to the non-latching kitchen doors until the project can be completed. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> All fire doors in healthcare have been checked to ensure that they latch appropriately. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> An item has been added to the Fire Drill Report that includes checking all fire doors to ensure that they latch during the fire drill (Appendix C). <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> The Safety Committee and 		

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K0046 SS=C	<p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 7 of 7 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour (90 minute) duration. 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. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0046	<p>the Quality Assurance Committee will review the check-off sheet for the next 7 months to ensure that the doors are latching correctly</p> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> 2/17/12 <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> Nowak Supply Co. has retested all generator-supported emergency lighting for the appropriate time of 90 minutes on 1/5/12 (see Appendix D for the Inspection Report) <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> All 10 emergency lights and exit signs have been tested on 1/5/12 <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> The contractor, Nowak Supply Co. has changed their 	01/05/2012

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	<p>Based on observation with Maintenance Director and the Maintenance Assistant on 12/21/11 from 11:00 p.m. to 1:45 p.m., seven battery operated emergency lights were observed throughout the facility. Based on record review of the Nowak Supply Co. Inc. untitled document at 11:00 a.m., seven battery operated emergency lights were test for sixty minutes on 12/06/11. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>procedure to test the emergency lights for 90 minutes instead of 60 minutes</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> The maintenance director will monitor the next emergency light testing and report the findings to the Safety Committee and the Quality Assurance Committee <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> 1/5/12 		
K0048 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written fire plan that included the use of all fire extinguishers including the</p>	K0048	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> The Fire Disaster Plan has 	01/06/2012	

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	<p>kitchen fire extinguishers for the protection of 63 of 63 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect any number of occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Director and the Maintenance Assistant on 12/21/11 at 11:01 a.m., the "Emergency Preparedness Plan" documentation did not address the preparation of floors for evacuation and the use of the fire extinguishers including the K class</p>		<p>been updated to include a specific designation of where residents need to be moved to for safety (Appendix E). The updated policy also directs the person in charge of moving residents to ensure that the location that the residents will be moved to is safe and ready for the residents.</p> <ul style="list-style-type: none"> · The Floor Plan for Christian Care has been updated to include color coded markings for fire walls, fire exits, fire doors, fire extinguishers, and evacuation routes (Appendix F). · A Fire Extinguisher Policy has been created to explain the appropriate uses of the fire extinguishers including the kitchen extinguisher as it relates to the hood (Appendix G). <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> · The new policy updates cover all residents <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> · Policies will be reviewed annually by the appropriate staff. <p>How the corrective action(s) will be monitored to ensure the</p>		

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K0143 SS=E	<p>fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>Transferring of oxygen is:</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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1</p>	K0143	<p>deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> The Quality Assurance Committee will ensure annually that the policies have been reviewed by the appropriate staff. <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> 1/6/12 <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> An additional layer of 5/8" drywall was installed in the oxygen room ceiling so that two layers would meet the requirement of needing a complete barrier of 1 hour fire 	01/06/2012	

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	<p>hour fire resistive construction. This deficient practice could affect any of 25 residents in the Plum Tree hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and the Maintenance Assistant on 12/21/11 at 12:02 p.m., after the Maintenance Assistant removed the ceiling vent cover, it was confirmed the ceiling of the oxygen room was constructed of one layer of five eights inch drywall. This was acknowledged by the Maintenance Director and the Maintenance Assistant at the time of observation. Additionally, the door entering the oxygen room lacked proper signage stating "transfilling in progress".</p> <p>3.1-19(b)</p>		<p>resistant construction. Glass Drywall was the company that completed the installation on 1/6/2012 (Appendix J).</p> <ul style="list-style-type: none"> A magnetic sign saying "Caution Oxygen Filling in Progress" was created to be put on the outside of the oxygen room door when filling oxygen (Appendix K). An inservice was completed to inform nursing staff and our oxygen filling company of the new procedures to use the sign when filling oxygen (Appendix L). <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> All residents use oxygen from the same oxygen room. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> If any changes to the oxygen room occur, a thorough evaluation will occur to determine if the changes meet Life Safety codes. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p>		

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K0144 SS=C	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 the complete documentation for the testing and weekly visual inspection of 1 of 1 emergency generators providing power to the emergency systems. NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds of the loss of normal power. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly	K0144	and · The Safety Committee and the Quality Assurance Committee will review all remodel projects going forward to ensure that safety issues have been addressed By what date the systemic changes will be completed. · 1/6/12 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · The generator is scheduled to automatically run weekly. A weekly checklist is completed to ensure all testing information is recorded (Appendix M) · Whenever the staff member assigned to the generator is gone or on vacation, the maintenance director will assign another staff member to record the checklist. · The transfer time will be recorded on the checklist on the first week of the month. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	01/06/2012	

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	<p>maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the generator log "Generator Weekly Checklist" with the Maintenance Director and the Maintenance Assistant on 12/21/11 at 10:27 a.m., the following was noted:</p> <p>a) a weekly inspection was not documented for the first week in August, the second week in October and the fourth week in November of 2011. Based on an interview with the Maintenance Director at the time of record review, the generator is scheduled to run automatically every week. The individual performing the weekly inspections was on vacation.</p>		<p>action(s) will be taken;</p> <ul style="list-style-type: none"> · The generator checklist covers the generator power for the entire building. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> · The maintenance director will audit the generator weekly checklist on a monthly basis to ensure that it is being fully completed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> · The maintenance director will report the compliance of the generator weekly checklist to the Quality Assurance Committee for 7 months. <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> · 1/6/12 		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>b) the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator for the months of October and November. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>				