

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2013
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NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 LAMMERS PIKE BATESVILLE, IN 47006
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K010000	<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: 08/19/13</p> <p>Facility Number: 004671 Provider Number: 155742 AIM Number: 200538760</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St Andrews Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare</p>	K010000		
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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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	<p>portion of the facility has a capacity of 66 and had a census of 59 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 Service Hall corridor doors was provided with latching hardware. This deficient practice could affect 42 residents who use the main dining room, located across the corridor from the employee breakroom.</p> <p>Findings include:</p> <p>Based on observation on 08/19/13 at 11:00 a.m. with the director of plant operations, the employee breakroom door was not provided with latching hardware. This was verified by the director of plant operations at the time of observation and acknowledged by the executive director at the exit conference on 08/19/13 at 2:40 p.m.</p> <p>3.1-19(b)</p>	K010018	No residents were found to have been affected by this alleged deficient practice. All residents had the potential to be affected by this alleged deficient practice. Latching hardware will be installed on the employee breakroom door by 9/13/13. All managers will be inserviced by 9/13/13 on the importance of appropriate latches on all doors of the facility. All facility doors will be monitored for proper latching once per week until 100% compliance is maintained for 3 months. Director of Plant Ops and ED will monitor. This will be reported in the monthly Quality Assurance meeting and the Committee will determine the need for further interventions. 9-13-13.	09/13/2013

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 42 residents who use the main dining room, located across the corridor from the laundry room.</p> <p>Findings include:</p> <p>Based on observations with the director of plant operations on 08/19/13 at 11:50 a.m., the laundry room ceiling above both dryers had two, twelve inch by twelve inch square areas of double drywall separated from the ceiling and lying on the top of each dryer. This was verified by the director of plant operations at the time of observation and acknowledged by the executive director at the exit</p>	K010025	No residents were found to have been affected by this alleged deficiency. All residents have the potential to be affected by this alleged deficiency. Prior to 9/13/13, all managers will be inserviced/educated on the proper smoke barriers and on how this barrier is maintained. Plant Operations Director and ED will monitor all ceilings once per week for breaks in the smoke barrier. This will be done until 100% compliance is maintained for 3 months. Quality Assurance Committee will determine need for any further compliance. 9-13-13	09/13/2013			

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	conference on 08/19/13 at 2:40 p.m. 3.1-19(b)			

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K010144 SS=C	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K010144	<p>No resident was found to have been affected by this alleged deficiency. All residents have the potential to be affected by this alleged deficiency. Director of Plant Operations and other management staff will be inserviced/educated by 9/13/13 on the regulation for monthly load test for the generator and need for documentation of same. A monthly load test will be conducted and documented prior to 9/13/13. This load test will be performed monthly, documented and reported to the Quality Assurance Committee monthly for 6 months. The QA Committee will determine and direct the need for further intervention. DPO and ED responsible. 9/13/13</p>	09/13/2013
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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Emergency Generator Load Test Log Sheet with the director of plant operations on 08/19/13 at 10:40 a.m., the Emergency Generator Load Test Log Sheet listed the amperage readings of the three branches of power over the past twelve monthly load tests conducted. Furthermore, the amperage readings of the three branches of power did not show the mathematical calculations converted to a percentage of load on each monthly load test. This was verified by the director of plant operations at the time of record review and acknowledged by the executive director at the exit conference on 08/19/13 at 2:40 p.m.</p> <p>3.1-19(b)</p>				