

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  03/24/2014
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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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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: 03/24/14</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</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</p>	K010000	<p>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 provide 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.</p>	
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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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 133 and had a census of 108 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/31/14.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010029 SS=E	<p>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 permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 2 St. Paul shower rooms used for storage of soiled linen therefore creating a hazardous area was provided with a functioning self closing device, and would latch into the door frame. This deficient practice could affect at least 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 03/24/14 from 1:00 p.m. to 3:30 p.m., the door closer for the St. Paul Birch Street shower room was disconnected. There were two forty four gallon soiled linen barrels in the room. Based on interview at the time of observation, the Property Manager acknowledged the barrels are stored in the shower room and they were unaware</p>	K010029	The door closer for the St. Paul Birch Street shower room was reconnected and operating properly. Currently all barrels are 32 gallon or smaller. Weekly environmental checklist updated to ensure the door closers are connected and working. Q/A to monitor monthly for 12 months. Property Manager responsible to ensure systemic changes completed.	04/21/2014			

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	the door closer had been disconnected.				

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K010038 SS=E	<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 7 means of egress exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice has the potential to affect 10 alert and oriented residents without a diagnosis for specialized security measures, visitors, and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/24/14 with the Property Manager during the tour from 1:00 p.m. to 3:30 p.m., the St. Paul dining room side exit door was equipped with a magnetic locking system but</p>	K010038	A posted code was put up by the St. Paul dining room side exit door. Weekly environmental check list updated to ensure posted codes are by egress exits.Q/A to monitor monthly for 12 months. Property Manager responsible to ensure systemic changes completed.	04/21/2014			

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	<p>lacked a posted code or instructions describing the code. Based on interview at the time of observation, the Property Manager acknowledged the code was not posted and the St. Paul dining room is not a portion of the facility with residents with clinical needs requiring specialized security measures.</p> <p>3.1-19(b)</p>			
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K010050 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to ensure 2 of 9 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Alarm/Fire Drill Reports on 03/24/14 from 11:15 a.m. to 1:00 p.m. with the Property Manager, the documentation for the drills performed on 01/24/13 and 05/13/13 between the hours of 6:00 a.m. and 9:00 p.m. lacked</p>	K010050	Will document on fire drill forms that monitoring station received alarm. Inservice for staff on all shifts by 4-21-2014.Q/A to monitor monthly for 12 months. Property Manager responsible to ensure systemic changes completed.	04/21/2014			

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	<p>verification of the transmission of the fire alarm signal. Based on interview at the time of record review, the Property Manager acknowledged the transmission of the fire alarm signal to the monitoring station was not documented for the aforementioned fire drills.</p> <p>3.1-19(b) 3.1-51(c)</p>			

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1) Based on observation and interview, the facility failed to ensure medical equipment electrical devices were not plugged into powerstrips or non fused extension cords as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, 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 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Property Manager from 1:00 p.m. to 3:30 p.m. during a tour of the facility on 03/24/14, the following was noted:</p> <p>a) A nebulizer was plugged into a power strip in room B16.</p> <p>b) A heating pad was plugged into a extension cord in resident room B6.</p> <p>c) The bed in room 5 was plugged into a powerstrip.</p> <p>Based on interview at the times of</p>	K010147	All medical equipment will be plugged into permanent wall outlets. Extension cord removed from resident room B-6. Orange electrical cord was removed. Proper emergency outlet install by licensed electrical contractor. In-service staff on proper usage of power strips and not plugging medical equipment into anything but the permanent wall outlets and not to use extension cords. Q/A to monitor montly for 12 months. Property Manager responsible to ensure systemic completed.	04/21/2014			

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	<p>observation, the Property Manager acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure flexible cord electrical wiring used in the basement was in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure.</li> <li>2. Where run through holes in the walls, structural ceilings, suspended ceilings, dropped ceilings; or floors.</li> <li>3. Where run through doorways, windows, or similar openings.</li> <li>4. Where attached to building surfaces.</li> <li>5. Where concealed behind walls, structural ceilings, dropped ceilings or floors.</li> <li>6. When installed in raceways, except otherwise permitted in this Code.</li> </ol> <p>This deficient practice would not directly affect residents but could affect staff in the service areas.</p> <p>Findings include:</p> <p>Based on observation on 03/24/14 during a tour of the facility from 1:00 p.m. to</p>				

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	<p>3:30 p.m. with the Property Manager, there was 20 foot length of orange electrical cord that came through the poured concrete ceiling of the basement in one area and back up through the ceiling in a different area. Based on interview at the time of observation, the Property Manager indicated the cord ran from an emergency powered electrical receptacle on the ground floor into the basement and backup through the ceiling to a water softener.</p> <p>3.1-19(b)</p>			

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K030000	<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: 03/24/14</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</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</p>	K030000	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 provide 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.				

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	<p>corridors, in 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 108 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.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K030050 SS=C	<p>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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 2 of 9 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Alarm/Fire Drill Reports on 03/24/14 from 11:15 a.m. to 1:00 p.m. with the Property Manager, the documentation for the drills performed on 01/24/13 and 05/13/13 between the hours of 6:00 a.m. and 9:00 p.m. lacked</p>	K030050	Will document on fire drill forms that monitoring station received alarm. Inservice for staff on all shifts by 4-21-2014.Q/A to monitor monthly for 12 months. Property Manager responsible to ensure systemic changes completed.	04/21/2014			

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	<p>verification of the transmission of the fire alarm signal. Based on interview at the time of record review, the Property Manager acknowledged the transmission of the fire alarm signal to the monitoring station was not documented for the aforementioned fire drills.</p> <p>3.1-19(b) 3.1-51(c)</p>			
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