

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
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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: 07/10/13</p> <p>Facility Number: 000117 Provider Number: 155210 AIM Number: 100266460</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Greensburg 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 one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms.</p>	K010000	Heritage House of Greensburg is dedicated to provide a safe environment for all residents, staff, and visitors. This facility respectfully requests acceptance of this required Plan of Correction submitted as our Allegation of Compliance. The completion of the following corrective measures by this facility ensures compliance on: August 10, 2013	

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>The facility has a capacity of 87 and had a census of 59 at the time of this visit.</p> <p>All areas where 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 07/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 sets of smoke barrier doors were equipped with an automatic releasing mechanism to release and remain self closing. LSC 19.2.2.2.6 permits smoke barrier doors to be held open only by an automatic release device that complies with 7.2.1.8.2. 7.2.1.8.2 (4) requires, upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. This deficient practice affects 23 residents who reside on the Station 2 Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 at 2:55 p.m. with the maintenance supervisor, the fire alarm system was activated and</p>	K010021	K 0021 No one was affected by this deficiency. Corrective measures will address those residents, staff, and visitors with the potential to have been affected. The one set of smoke barrier doors on Station 2 that failed to function as required during activation of the fire alarm system is scheduled for service with Safecare to properly restore the automatic releasing mechanism. All other smoke barrier doors have been checked to ensure compliance. All 10 sets of smoke barrier doors will be monitored by maintenance department at least monthly upon activation of the fire alarm system.	08/10/2013

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	<p>alarming in the facility. During the fire alarm system test, the Station 2 Hall north set of smoke barrier doors magnetic releasing devices released the set of smoke barrier doors, however, the Station 2 Hall charge nurse pushed the Station 2 Hall north set of smoke barrier doors into the open position, and the set of smoke barrier doors remained open due to the remagnetized releasing devices. The Station 2 Hall north set of smoke barrier doors remagnetizing and remaining in the open position while the fire alarm system was alarming was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/10/13 at 3:45 p.m.</p> <p>3.1-19(b)</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 2 of 2 corridor doors to the Laundry Hall storage room, a hazardous area used for soiled linen storage, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 16 residents who reside on the Station 4 Hall, located adjacent to the Laundry Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 at 12:25 p.m. with the maintenance supervisor, self closing devices were not provided on the two doors leading into the Laundry Hall storage room, which stored seven, 32 gallon soiled linen containers. This was verified by the maintenance supervisor at the time of</p>	K010029	K 0029 No one was affected by this deficiency. It is the practice of this facility to provide for fire and safety awareness at all times. The corrective actions will address those who have potential to be affected by this finding. Self closing devices have now been installed on the two doors leading into the laundry hall storage room. All other designated storage rooms have been checked to ensure self closing devices are also installed on those doors considered to be hazardous areas. Maintenance will monitor during routine daily facility rounds to ensure compliance that all designated storage areas are equipped with a self closing door device.	08/10/2013			

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	<p>observation and acknowledged by the administrator at the exit conference on 07/10/13 at 3:45 p.m.</p> <p>3.1-19(b)</p>			

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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>1. Based on observation and interview, the facility failed to ensure 2 of 10 corridor sets of smoke barrier doors and 1 of 12 exit doors' electromagnetic locks remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice affects 23 residents who reside on the Station 2 Hall.</p> <p>Findings include:</p> <p>Based on observations during a test of the fire alarm system on 07/10/13 with the maintenance supervisor at 2:45 p.m., the electromagnetic locks on the Station 2</p>	K010038	<p>K 0038 1. The facility is dedicated to support fire prevention and safety awareness at all times. No one was affected by this finding. The two sets of corridor smoke barrier door and the 1 set of exit doors that did not release and unlock upon activation of the alarm system are within our Special Care Unit on Station 2. This area is designated where the clinical needs of our residents require special security measures for their safety to prevent them from leaving the unit unauthorized, and potentially harming themselves or others. The Special Care Unit doors are equipped with the automatic delayed egress to unlock in 15 seconds, but the electromagnetic locks to hold doors open have been disengaged. Staff who work on our Special Care Unit where residents reside with Alzheimer's or other dementia related conditions have keys or a device to unlock the doors at all times. This is in accordance with (Code Reference: 19.2.2.2.4, Exception No. 1, 2000 edition of the LSC).</p> <p>2. No one with the potential for harm was affected by this deficiency. The corrective action will protect those residents, staff, and visitors who may use this exit</p>	08/10/2013

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	<p>Hall west set of smoke barrier doors, the Station 2 Hall east set of smoke barrier doors, and the Station 2 Hall exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/10/13 at 3:40 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 12 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 16 residents who reside on the Station 4 Hall who would use the Station 4 Hall exit.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 at 1:50 p.m. with the maintenance supervisor, the</p>		<p>door on Station 4 hall. This finding of a broken four foot section of concrete sidewalk surface extending to the parking lot will be replaced at this exit. Maintenance Department will observe all sidewalk surfaces at least weekly during routine maintenance rounds to ensure all sidewalk surfaces are maintained to prevent elevations changes.</p>	

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	<p>Station 4 Hall exit discharged onto a concrete sidewalk extending seventy eight feet to the parking lot. The four foot section of concrete sidewalk connected to the asphalt parking lot was completely broken in twelve separate pieces of concrete and heaving in three areas with a two inch change in the sidewalk elevation. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/10/13 at 3:40 p.m.</p> <p>3.1-19(b)</p>			

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K010062 SS=E	<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>Based on observation and interview, the facility failed to ensure 2 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 36 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 07/10/13 during a tour of the Dining Service Hall with the maintenance supervisor from 11:45 a.m. to 12:25 p.m., the Dining Service Hall corridor outside the dietary manager office, and the dietary manager office each had a sprinkler head escutcheon not flush to the ceiling leaving a three quarter inch gap into the attic space above. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/10/13 at 3:45 p.m.</p> <p>3.1-19(b)</p>	K010062	<p>K 0062 It is the intent of this facility to provide a safe environment for all residents, staff, and visitors at all times. No one was affected by this deficient practice. The corrective actions will address those with the potential to have been affected. The 2 of over 300 sprinkler heads listed as sprinkler escutcheons not being flush to the ceiling to prevent gaps into the above attic space have both been maintained again to ensure each one is reliable and in operating condition. The remainder of sprinkler heads were also inspected to assure all others are functional. Maintenance will continue to monitor daily, inspect annually and implement modifications as needed to support fire prevention and safety.</p>	08/10/2013			

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/10/13 during a tour of the facility from 11:00 a.m. to 3:45 p.m. with the maintenance supervisor, all rooms in the facility used the egress corridors as a return air system for the air conditioning system in the facility. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/10/13 at 3:45 p.m.</p>	K010067	K 0067 Heritage House of Greensburg respectfully requests a continuing waiver be granted for this deficiency. PLEASE SEE ATTACHMENT A AND THE ANNUAL LIFE SAFETY CODE WAIVER REQUEST FOR FOR YOUR REVIEW AND CONSIDERATION.	08/10/2013			

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