

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/26/2012
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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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: 11/26/12</p> <p>Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Homewood Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111)</p>	K0000		

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>construction and fully sprinklered.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 55 and had a census of 53 at the time of this survey.</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 12/04/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0029 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 a wall in 1 of 6 hazardous areas was maintained to provide a smoke resistant wall. This deficient practice could affect visitors, three staff and 20 or more residents in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/26/12 at 11:15 a.m., a draft was felt from a one inch opening in the kitchen wall through which a piece of plastic pipe protruded. The Director of Plant Operations said at the time of observation, the opening vented a juice</p>	K0029	<p>The one inch opening in the kitchen wall was immediately repaired to maintain the smoke resistance of the wall that could affect visitors, staff, and residents in this area. All six (6) hazardous areas smoke resistance walls were checked for holes that could potentially affect all the staff, residents and visitors by the alleged deficient practice. All six (6) hazardous area smoke resistance wall will be checked each month times six (6) months to ensure the deficient practice does not recur. Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012	

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	<p>machine on the other side of the wall. He acknowledged the opening failed to maintain the smoke resistance of the wall.</p> <p>3.1-19(b)</p>			

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review and interview, the facility failed to provide a fire plan which included the use of 1 of 1 K-class fire extinguishers in conjunction with the overhead hood system in the written fire plan for the protection of all occupants. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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 affects staff, visitors, and 10 or more residents in the adjacent smoke compartment.</p> <p>Findings include:</p>	K0048	<p>The use of the K-class fire extinguishers in conjunction with the overhead hood system plan was immediately placed in the our written fire plans for the protection of all occupants in which this deficient practice affected staff, visitors, and 10 or more residents in the adjacent smoke compartment. All written fire plans were updated with the K-class fire extinguishers in conjunction with the overhead hood system plan which could potentially affect all the staff, residents and visitors by the alleged deficient practice. All written fire plans will be audited by the Director of Plant Operations/designee each month times six (6) months to ensure to ensure the deficient practice does not recur. Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012	

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	<p>Based on record review with the Director of Plant Operations on 11/26/12 at 2:40 p.m., the fire safety plan was incomplete. The fire safety plan did not identify the available K-class fire extinguisher located in the kitchen and address it's use in relationship with the kitchen overhead extinguishing system. The Director of Plant Operations acknowledged at the time of record review, these elements were not addressed in the fire plan.</p> <p>3.1-19(b)</p>				

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K0070 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors staff and any of the 53 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/26/12 at 12:20 p.m., a space heater was stored in a storage room on the 200 hall. A label on the heater read, "for emergency use only." The director of plant operations said at the time of observation, the space heater was to be used in the event a heater went out in a resident room. He acknowledged there was nothing to evidence the heating element would not exceed 212 degrees Fahrenheit and there was no</p>	K0070	<p>The portable space heating device located in a stroage room on the 200 hall was immediately removed from the facility in which the deficient practice could affect visitors, staff and any of the 53 residents.</p> <p>No portable space heating devices will be used in the campus to ensure the deficient practice does not recur.</p> <p>Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012	

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	<p>policy and procedure to govern it's use.</p> <p>3.1-19(b)</p>			

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered nursing supply storage rooms was properly separated from combustibles. NFPA 99, Health Standards for Health Care Facilities, 8-3.1.11.2(c)2 requires the minimum separation from oxygen and combustibles in a sprinklered building be 5 feet, or in an enclosed cabinet of noncombustible construction having a minimum fire protection rating of one half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. This deficient practice affects staff, visitors and 25 residents in the center smoke</p>	K0076	<p>The liquid oxygen storage container located in the nursing supply storage room was immediately removed and placed in the oxygen supply storage room in which this deficient practice affected visitors, staff and 25 residents.</p> <p>The oxygen storage area and nursing supply storage room will be checked daily times two weeks then weekly times 6 months. All oxygen will be stored in the oxygen room to ensure the deficient practice does not recur.</p> <p>Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012

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	<p>compartment.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/26/12 at 11:40 a.m., the nursing supply storage room was used for the storage of plastic, paper and cardboard wrapped respiratory supplies on shelves. A liquid oxygen storage container stood six inches from a supply laden shelf. The container was full. The Director of Plant Operations said at the time of observation, the oxygen should have been stored in the oxygen supply storage room.</p> <p>3.1-19(b)</p>				

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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: 11/26/12</p> <p>Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Homewood Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The addition to the 300 hall built after March 2003 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This addition to the 300 hall was</p>	K0000	<p>Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations.</p> <p>Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review or a request for a revisit immediately after 12.16.12 .</p>	

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	<p>determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 55 and had a census of 48 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a fire plan which included the use of 1 of 1 K-class fire extinguishers in conjunction with the overhead hood system in the written fire plan for the protection of all occupants. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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 affects staff, visitors, and 10 or more residents in the adjacent smoke compartment.</p> <p>Findings include:</p>	K0048	<p>The use of the K-class fire extinguishers in conjunction with the overhead hood system plan was immediately placed in the our written fire plans for the protection of all occupants in which this deficient practice affected staff, visitors, and 10 or more residents in the adjacent smoke compartment. All written fire plans were updated with the K-class fire extinguishers in conjunction with the overhead hood system plan which could potentially affect all the staff, residents and visitors by the alleged deficient practice. All written fire plans will be audited by the Director of Plant Operations/designee each month times six (6) months to ensure to ensure the deficient practice does not recur. Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012	

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	<p>Based on record review with the Director of Plant Operations on 11/26/12 at 2:40 p.m., the fire safety plan was incomplete. The fire safety plan did not identify the available K-class fire extinguisher located in the kitchen and address it's use in relationship with the kitchen overhead extinguishing system. The Director of Plant Operations acknowledged at the time of record review, these elements were not addressed in the fire plan.</p> <p>3.1-19(b)</p>			
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K0070 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors staff and any of the 53 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/26/12 at 12:20 p.m., a space heater was stored in a storage room on the 200 hall. A label on the heater read, "for emergency use only." The director of plant operations said at the time of observation, the space heater was to be used in the event a heater went out in a resident room. He acknowledged there was nothing to evidence the heating element would not exceed 212 degrees Fahrenheit and there was no</p>	K0070	<p>The portable space heating device located in a stroage room on the 200 hall was immediately removed from the facility in which the deficient practice could affect visitors, staff and any of the 53 residents.</p> <p>No portable space heating devices will be used in the campus to ensure the deficient practice does not recur.</p> <p>Director of Plant Operations/designee will report each month to the QA committee for 6 months to ensure the deficient practice will not recur.</p>	12/16/2012			

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	<p>policy and procedure to govern it's use.</p> <p>3.1-19(b)</p>				