

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155519	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/01/2012
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NAME OF PROVIDER OR SUPPLIER  GENTLECARE OF VINCENNES	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST VINCENNES, IN 47591
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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: 11/01/12</p> <p>Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Gentlecare of Vincennes 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 with a basement was determined to be of Type V (000) construction and was</p>	K0000	<p>This plan of correction is submitted to serve as an allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the allegations or conclusions set forth in the statement of deficiencies.</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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	<p>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 which were also addressable to the fire alarm system via a wireless system. The facility has a capacity of 60 and had a census of 46 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached wood sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/09/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 2 of 8 hazardous area room doors such as a kitchen service window opening were equipped with self closing devices on the doors. This deficient practice could affect residents, as well as staff and visitors while in the Dining Room which had a capacity of 40 at the time of this survey.</p> <p>Findings include:</p> <p>Based on observation on 11/01/12 at 11:00 a.m. during a tour of the facility with Maintenance Supervisor, the kitchen service window between the dining room and kitchen</p>	K0029	<p><b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b>Per ISDH findings, no actual harm was found in 46 of 46 residents.<b>RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b>Residents, as well as staff and visitors (while in the dining room) were found to have the potential to be affected causing the following actions.<b>CORRECTIVE MEASURES/SYSTEMIC CHANGES:</b>Kitchen service window opening doors will be replaced by a smoke resistant wall. Kitchen service window doors will be removed and a permanent wall will be constructed in their place.The permanent wall will act as a smoke resistant partition between the facility kitchen and facility dining room.<b>CORRECTIVE MEASURES MONITORED:</b>Removal of service</p>	12/01/2012			

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	<p>consisted of two wood doors which were not provided with self closing devices, furthermore, the doors did not latch into the door frame when closed. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>window doors and construction of a permanent wall (without openings) between kitchen and dining room will prevent recurrence of this practice. Maintenance will inspect integrity of wall weekly and report to administrator. Administrator will report inspection results to monthly CQI committee. The role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p>		

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K0050 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 fire drills were held at varied times for 2 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills folder on 11/01/12 at 9:00 a.m. with the Maintenance Supervisor present, three of four second shift (evening) fire drills conducted since November of 2011 were performed between 3:10 p.m. and 4:00 p.m., furthermore, three of four third shift (night) fire drills conducted since November of 2011 were performed between 3:00 a.m. and 3:20 a.m. During an interview at</p>	K0050	<p>Corrective action for residents found to have been affected:Per ISDH findings, no actual harm was found in 46 of 46 residents.<b>Residents having the potential to be affected:</b>All residents were found to have the potential to be affected causing the following corrective actions. Corrective Measures/Systemic Changes:Facility will implement revised Fire Drill Report (Exhibit A). This form will require documented and varied times for fire drills. (Exhibit A, item #1) Maintenance Supervisor will be in-serviced on revised form. Administrator will determine all fire drill dates and times. Administrator will review Fire Drill Reports within 24 hours following the fire drill. Corrective Measures Monitored:To prevent recurrence of this practice, Administrator will determine all fire drill dates and times and Maintenance will present all documented Fire Drill Reports to</p>	12/01/2012			

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	<p>the time of record review, the Maintenance Supervisor acknowledged the times of the second and third shift fire drills were not varied.</p> <p>3-1.19(b)</p>		<p>the Administrator for review. Maintenance will report results of monthly Fire Drill Reports to the Administrator and the Administrator will report to the monthly CQI Committee. The role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p>		