

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714
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K 0000 Bldg. 01	<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: 08/26/16</p> <p>Facility Number: 000465 Provider Number: 155501 AIM Number: 100273870</p> <p>At this Life Safety Code survey, Signature Healthcare of Bluffton 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 108 and had a census of 44 at</p>	K 0000	<p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared solely because of federal and state law.</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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K 0025 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the maintenance office, maintenance supplies and tools that was not sprinklered</p> <p>Quality Review completed on 08/29/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between</p>	K 0025	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; a) Fourth of an inch penetration around a wire located in attic by room 501smoke barrier wall to be sealed with 3M Fire Barrier Sealant, CP 25WB+, ProductColor "Red". B) Drywall to be replaced on both sides in Bridgeattic of smoke barrier wall, and sealed with 3M Fire Barrier Sealant, CP</p>	09/22/2016

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	<p>the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 25 residents in 4 of 9 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 8/26/16 from 1:10 p.m. to 1:35 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) In the attic of the smoke barrier wall by room 501 there was an unsealed fourth of an inch penetration around a wire.</p> <p>b) In the attic of the smoke barrier wall to Bridge hall part of the drywall was removed leaving a two foot by four foot hole through the wall.</p> <p>Based on interview at the time of observation, the Plant Operations Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>		<p>25WB+,Product Color "Red". How other residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; Noothor areas were identified.What measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The PlantOperations Director will monitor and log facility safety of penetrations bystaff and/or contractors involving work being performed in the building monthlyper TELS preventative maintenance system. How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; The Plant Operations Director will monitor andcomplete inspection log(s) via TELS electronic preventative maintenance systemPenetration Log on a weekly basis. The QualityAssurance Committee will review monthlyfor compliance and recommend furtheraction if indicated.</p>	

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1 of 3 corridor doors to a mechanical room with a fuel fired water heater, a hazardous area, was provided with self-closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 15 residents in the 500 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Plant Operations Director on 08/26/16 at 12:20 p.m., the maintenance closet door in the 500 hall did self-close but failed to latch into the frame due to the door rubbing on the frame. The maintenance closet contained</p>	K 0029	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; The Maintenancecloset door by laundry entrance at end of 500 hall was inspected due to rubbingon frame on 09/02/16. It was determinedexcess paint on frame was causing rubbing, thus not allowing the door to latchproperly. Excess paint removed andslight frame adjustment completed on 09/02/16. Tested and passed 09/02/16 by Plant Operations Director. How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken; No other areas were identified. What measures will be put into place or</p>	09/12/2016

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K 0048 SS=F Bldg. 01	<p>a fuel fired water heater. Based on interview, this was acknowledged by the Plant Operations Director at the time of observation.</p> <p>3.1-19(b)</p> <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 written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>			K 0048	<p>what systemic changes will be made to ensure that the deficient practice does not recur; The Plant Operations Director will include fuel fired water heater closets to the weekly door inspections logs via TELS Preventative Maintenance System Program. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Committee will review compliance of weekly door inspections logs on a monthly basis and make further recommendations as indicated.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The ERP books were updated with the revised Plant Operations Policy and Procedure dated November 2013 in regards to battery operated smoke detector alarms. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The Plant Operations Director</p>		09/07/2016

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K 0066 SS=E Bldg. 01	<p>(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 This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on a record review of the facility's fire plans with Plant Operations Director on 08/26/16 at 10:35 a.m. and again at 11:00 a.m., the plans located and the 300 hall nurses' station and in the maintenance office did not address response to the activation of a resident room battery operated smoke alarm. Based on interview at the time of records review, the Plant Operations Director did state the facility did have a response plan to battery operated smoke alarms and did provide a plan by printing it from the computer; but did acknowledge the response plan was not in the facility's fire plans.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p>		<p>to remove all outdated policy and procedures regarding battery operated smoke detector alarms from all facility ERP books and Manual (located in Maint. Dept) and will replace them with the latest revised policy and procedure dated November 2013. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Plant Operations Director will review and update all plan books annually and/or upon receiving new revisions of policy and procedure or regulations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Quality Assurance Committee will review any updates or changes to regulations or policy and procedure monthly as received and ensure that all plan books have been updated. Any updates will be noted in the Safety Committee notes monthly and reviewed by the Quality Assurance Committee for further action if indicated.</p>				

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	<p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 smoking areas were properly maintained by the proper disposal of cigarette butts and was provided with a self-closing receptacle used to empty ashtrays only. This deficient practice was not in a resident care area but could affect any staff using the break room exit.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 08/26/16 at 12:38 p.m., in the staff smoking outside the employee brake room exit the following was noted:</p>	K 0066	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; The Smoking area for staff was observed fornon-compliance of materials and equipment. A list was completed on Aug. 29,2016 of required materials and/or equipment needed to ensure 100% compliance of smoking by staff in this outdoor area offbreakroom. The following is a list ofitems ordered: Patty ashtrays w/lid -8/30/16, Justrite Smoker Bucket Liners - 9/1/16, Round Top Waste Receptaclew/self-closing lid - 9/1/16, Rolled Rim Receptacle w/self-closing lid - 9/1/16.All Staff</p>	09/22/2016

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	<p>a.) There was a trash can with over 40 cigarette butts mixed with combustibles.</p> <p>b.) There were 10 plus cigarette butts on the ground.</p> <p>c.) There were two uncovered ash trays in use containing cigarette butts.</p> <p>d.) The area did not contain a self-closing receptacle used to empty ashtrays. Base on interview at the time of observation, the Plant Operations Director acknowledged the cigarette butts and that the smoking area did not have a metal container with a self-closing covered receptacle provided to empty ashtrays or properly dispose of cigarette butts.</p> <p>3.1-19(b)</p>		<p>will be inserviced on Smoking Protocol by the Plant Ops Director.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other areas were affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant Operations Director and/or designee to monitor smoking materials and/or equipment for compliance monthly per Safety Committee rounds and report findings to the Quality Assurance Committee for further follow up if indicated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Safety Committee will monitor compliance with Smoking Protocol and equipment through monthly audit and report any findings to the Quality Assurance Committee for further action if indicated</p>	