

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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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: 03/04/14</p> <p>Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Providence Home Health Care Center 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 two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the</p>	K010000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 4/3/14 to the state findings of the annual Life Safety Code survey conducted 3/4/14</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>corridors, in spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 47 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 one detached garage used for facility storage, a generator building, and a greenhouse.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 30 doors to the corridor on the first floor was equipped with a positive latch and would latch into the door frame. This deficient practice could affect up to 17 residents, as well as staff and visitors on the first floor.</p> <p>Findings include:</p> <p>Based on observation on 03/04/14 at 12:15 p.m. during a tour of the facility with the Environmental Director and the Housekeeping Supervisor, the door to the first floor former shower room on the north side of the corridor was not provided with a positive latch. There was only a deadbolt lock on the door.</p>	K010018	<p>The corrective action taken for those residents found to have been affected by the deficient practice is that no residents were identified as having been affected. The corrective action taken for those residents having the potential to be affected by the deficient practice is that the door identified as the former shower room door now has a positive latch door knob installed. The measures that have been put into place to ensure the deficient practice does not recur is that a positive latch door knob was installed on the former shower room door.</p> <p>The corrective action taken to monitor to ensure compliance is that the maintenance department will monitor the positive latch door knob during regularly scheduled preventative</p>	04/03/2014			

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K010029 SS=F	<p>This room is now used for a small amount of storage items, but not enough to be considered a hazardous area. This was acknowledged by the Environmental Director and the Housekeeping Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 2 of 2 doors to the kitchen, hazardous area doors, were equipped with positive latches which latched into the door frames. This deficient practice could affect all residents, as well as staff and visitors while in the dining room which was large enough to seat all residents.</p> <p>Findings include:</p>	K010029	<p>maintenance rounds to ensure it is functioning properly.</p> <p>1.) The corrective action taken for those residents found to have been affected by the deficient practice is that no residents were identified as having been affected. The corrective action taken for those residents having the potential to be affected by the deficient practice is that the two kitchen doors identified as not having positive latch door knobs now have positive latch door knobs installed. The corrective measures that have been put into place to ensure the deficient</p>	04/03/2014			

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	<p>Based on observations on 03/04/14 at 11:30 a.m. and again at 11:32 a.m. during a tour of the facility with the Environmental Director and the Housekeeping Supervisor, the main kitchen door and the kitchen service door/window between the kitchen and dining room were not provided with positive latches. Both were equipped with deadbolt latches only. Furthermore, the main kitchen door did not close completely when tested, there was a one inch gap between the entire length of the door and its frame. This was acknowledged by the Environmental Director and the Housekeeping Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 10 hazardous area room doors, such as rooms over 50 square feet in size containing combustible material, were equipped with self closing devices on the doors. This deficient practice could affect mostly staff, plus any residents or visitors while in the Administrator's Office/short corridor area.</p> <p>Findings include:</p>		<p>practice does not recur is that two positive latch door knobs have been installed on the two kitchen doors. The corrective action taken to monitor to ensure compliance is that the maintenance department will monitor the two positive latch door knobs during regularly scheduled preventative maintenance rounds to ensure they are functioning properly. 2.) The corrective action taken for those residents found to have been affected by the deficient practice is that no residents were identified as having been affected. The corrective action taken for those residents having the potential to be affected by the deficient practice is that the two doors identified as not having self closing devices now have self closing devices installed. The measures that have been put into place to ensure the deficient practice does not recur is that self closing devices were installed on each door.</p> <p>The corrective action taken to monitor to ensure compliance is that the maintenance department will monitor the two self closing devices during regularly scheduled preventative maintenance rounds to ensure the self closing devices are functioning properly.</p>				

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K010038 SS=C	<p>Based on observations on 03/04/14 at 11:45 a.m. and 11:50 a.m. during a tour of the facility with Environmental Director and the Housekeeping Supervisor, the Record storage/Resident clothes storage room door and the office (Father Thad's former office) room door were not provided with self closing devices. Both rooms were over fifty square feet and contained a large amount of combustible material such as cardboard boxes, paper, and plastic items. This was acknowledged by the Environmental Director and the Housekeeping Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <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 the means of egress through 8 of 8 locked emergency exits were readily accessible for residents and visitors. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/04/14</p>	K010038	The corrective action for those residents found to have been affected by the deficient practice is that no residents were identified as having been affected. The corrective action taken for those residents having the potential to be affected by the deficient practice is that signage with the four digit code have been posted by each of the eight emergency exits. The measures that have been put into place to ensure the deficient practice does	04/03/2014

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	<p>between 11:15 a.m. and 2:00 p.m. during a tour of the facility with the Environmental Director and the Housekeeping Supervisor, all eight emergency exit doors were magnetically locked and could be opened by entering a four digit code on a keypad located adjacent to the exit doors. The code was not posted at any of the emergency exit doors. This was acknowledged by the Environmental Director and the Housekeeping Supervisor at the time of each observation. During an interview at 1:50 p.m., the Environmental Director indicated residents in the facility where a mixed population of alert and cognitively impaired residents.</p> <p>3.1-19(b)</p>		<p>not recur is that all eight emergency exit doors have signage displaying the four digit code to unlock the door. The corrective action taken to monitor to ensure compliance is that the maintenance department will monitor for display of signage listing the four digit code during regularly scheduled preventative maintenance rounds.</p>		