

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/16/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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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: 07/16/14</p> <p>Facility Number: 000439 Provider Number: 155716 AIM Number: 100275070</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Good Samaritan Home Health Center and Residential was found in substantial 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 two separate basements was determined to be of Type II (222) construction for the original portion of the facility and Type V (111) construction for the remainder of the facility, including the Pathways 1,</p>	K010000	<p>Please accept the following Plan of Correction for the annual Life Safety Survey conducted on July 16, 2014</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies This Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State laws This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community</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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K010130 SS=B	<p>Pathways 2, and Pavilion. The facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors, in both basements, and in all resident sleeping rooms. The facility has a capacity of 212 and had a census of 179 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 and one plastic shed used for bio hazard waste.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/21/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, interview and record review; the facility failed to ensure 1 of 2 fuel fired water heaters in the</p>	K010130	Upon review of the finding noted in the Statement of Deficiencies, we request that this finding be deleted or amended. On April 8, 2013 at 8:21am, a call was	08/01/2014

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	<p>Pavilion had an inspection certificate that was current to ensure the water heater was in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect up to 15 residents as well as staff and visitors in the Pavilion.</p> <p>Findings include:</p> <p>Based on observation on 07/16/14 at 11:00 a.m. during a tour of the facility with Director of Facility Operations, there was no inspection certificate or inspection tag on one of the water heaters in the Pavilion mechanical room. The tag on the water heater said it was a 100 gallon tank water heater. This was a gas fired water heater. During an interview at the time of observation, the Director of Facility Operations acknowledged there was no inspection certificate or inspection tag on this 100 gallon gas fired water heater. Furthermore, the Director of Facility Operations said he has requested the State agency that inspects and tags the water heaters to come and inspect this particular water heater, but has not received confirmation back of an inspection date. The Director of Facility Operations also provided a written</p>		<p>placed to the State Agency for Boiler &amp; Pressure Vessels requesting an inspection be scheduled and completed on a newly installed 100-gallon tank water heater on our Pavilion unit. The State Agency was not able to act on our request, and therefore, the inspection was not completed. On October 10, 2013, a request was again sent via a fax cover sheet to the State Agency for Boiler &amp; Pressure Vessels requesting an inspection be scheduled and completed. However, the State Agency was again not able to act on our request, and therefore, the inspection was not completed. At that time, we were informed that the reason the State Agency could not complete the inspection was related to there being a vacancy in the State Agency Office for an inspector in this region. On July 16, 2014, we again submitted another request via a fax cover sheet to the State Agency to have the water heater inspected. We were informed by the State Agency Office that an inspector has been newly hired and would be starting in our region the following week. On July 24, 2014, our Interim Director of Nursing spoke with Kim Rhoades, Director, Division of Long Term Care to discuss this matter. Per their discussion, in addition to this Plan of Correction, documentation was requested to support our efforts to obtain the</p>				

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	request from the facility to the State agency to come and inspect the water heater which was dated 10/25/13.  3.1-19(b)		inspection. Additionally, on July 29, 2014, at approximately 2:25pm, our Interim Director of Nursing spoke with Mr. Steve Pauley, Assistant Director, State Agency for Boiler & Pressure Vessels. During that conversation, Mr. Pauley confirmed that the reason the inspection had not been completed was due to there being a vacancy in the inspector position in the State Agency Office since 2007 Mr. Pauley did confirm that he had supporting documents that confirmed our attempts to obtain the required inspection However, in relation to the received alleged deficiency, on July 30, 2014, another request for inspection was submitted to the State Agency via phone and certified mail. On August 1st, 2014 Tom George an inspector from the State Agency with the Boiler & Pressure Vessels Division visited the facility and completed the required inspection. Residents residing on the Pavilion unit have the potential to be affected by the alleged deficient practice The Director of Facility Operations has developed a tickler file systematic process for tracking regularly scheduled equipment inspections As new equipment is obtained that required official inspections, these will be added to the tickler file to ensure continued follow-up Additionally, the Director of Facility Operations will maintain		

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			letters and/or documentation supporting the date, time and person(s) to whom requests for official inspections were made The Facility Administrator will audit the tickler files on a bi-annual basis to ensure required inspections are being completed in accordance to State and Federal requirements The results of these audits will be presented to the Quality Assurance / Performance Improvement Committee on a bi-annual basis The Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated		