

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155512	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/19/2013
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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710
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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: 03/19/13</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Presence Sacred Heart Home 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) and 410 IAC 16.2. The original building consisting of the St. Anthony, St. Claire, St. Paul, and the St. Frances neighborhoods as well as the main dining room, chapel and service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully</p>	K010000		
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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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wire smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 117 at the time of this survey.</p> <p>All areas where the 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 03/28/13.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010029 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>1. Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the main kitchen, a hazardous area, would self close and latch into the door frame. This deficient practice could affect at least 20 residents in the activity area and residents evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager and the Administrator in Training on 03/19/13 at 2:35 p.m., the main kitchen door near the service hall fire door set partially closed and failed to latch into the door frame leaving a two inch gap between the door and the door frame. Based on an interview with the Property Manager at the time of observation, air movement prevented the main kitchen door from latching into the</p>	K010029	Contractor to install automatic power assist close modules to ensure that the deficient practice does not reoccur.A-1 Doors will do an assessment on all automatic fire latching devices in the facility.Bi-annually all automatic doors will be inspected by AAADM (American Association of Automatic Doors Manufactures) to ensure proper door operations. Property Manager responsibleQA to monitor at least 1 fire drill report quarterlyTime Extension requested forcontractors to submit quotesquotes sent to Presence Life Connections for approvalapproved contractor, order parts, schedule work Systemic changes completed by May 17, 2013	05/17/2013			

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	<p>door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 2 St. Paul shower rooms used for storage of soiled linen therefore creating a hazardous area, were provided with a self closing device and would latch into the door frame. This deficient practice could affect 6 residents.</p> <p>Findings include:</p> <p>Based on observations with the Property Manager and the Administrator in Training on 03/19/13 from 1:04 p.m. to 1:44 p.m., two forty four gallon soiled linen barrels, approximately one eighth full were unattended and stored in the St. Paul Birch Street shower room.</p> <p>Additionally, three forty four gallon soiled linen barrels, one completely full, were unattended and stored in the St. Paul Pine Street shower room. Both shower room corridor doors lacked self closing devices and failed to latch into the door frame. Based on an interview with the Administrator in Training at 1:44 p.m., the barrels are stored in the shower rooms until they are taken to the laundry room which occurs three times a day.</p>				

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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 3 of 8 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect at least 20 residents in the activity room and evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>a. Based on observations with the Property Manager and the Administrator in Training on 03/19/13 from 3:00 p.m. to 3:05 p.m., the fire door set separating Pine St. on St. Paul and the assisted living area have a magnetic locking system with handicap accessibility. The doors are designed to latch into the door frame upon activation of the fire alarm system. When the fire alarm was activated the doors</p>	K010044	<p>Latching mechanism will be installed to the St. Clare door to latch into door frame during a fire alarm activation. Contractor to check wiring device to ensure device is working correctly during a fire drill and monitor according to fire drill checklist. Bi-annually all automatic doors will be inspected by AAADM (American Association of Automatic Doors Manufacturers) to ensure proper door operations including, the Pine Street door on St. Paul and the main kitchen door. QA to monitor quarterly Property Manager responsible Time extension requested for: contractor evaluate changes and submit quotes sent to Presence Life Connections for approval approved contractor, order parts, schedule work Systemic changes will be completed by May 17, 2013</p>	05/17/2013			

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	<p>failed to latch into the door frame. Additionally, the fire door set entering St. Clair failed to latch into the door frame when the fire alarm was activated. The Property Manager confirmed the doors were fire doors at the time of observations.</p> <p>b. Based on observation with the Property Manager and the Administrator in Training on 03/19/13 at 2:30 p.m., upon activation of the fire alarm system, the fire doors entering the service hall failed to close completely and latch into the frame, leaving a two inch gap between the doors. Based on an interview with the Property Manager at the time of observation, these doors were confirmed to be fire doors and he thought air movement was preventing the doors from closing and latching into the frame.</p> <p>3.1-19(b)</p>			

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K010046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 111 residents.</p> <p>Findings include:</p> <p>Based on observations with Property Manager and the Administrator in Training on 03/19/13 during the tour of the facility from 11:19 a.m. and 3:05 p.m., eight battery operated emergency lights were observed throughout the facility. Based on an interview with the Property Manager at 11:20 a.m., an annual test for these emergency light fixtures has not been performed since 02/01/12.</p>	K010046	Annual test will be completed on the 8 battery emergency lights throughout the facility. The battery operated emergency lights test log form was downloaded from the LSC website and is being utilized by the facility. See attached supporting documentation #1QA to monitor quarterly Property Manager responsible Systemic changes completed by April 18, 2013	04/18/2013			

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K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the main kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice was not in a resident care area but could affect staff in the main kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 03/19/13 at 2:40 p.m., the</p>	K010064	The correct placard was permentanly afixed to the wall above the kitchen K Class fire extinguisher in the main dietary kitchen, identifying its use as a secondary backup to the kitchen automatic fire suppression system. Property Manager is responsible Systemic changes completed by April 18, 2013	04/18/2013			

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	<p>kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Property Manager at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>				

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure soiled linen containers with a capacity of more than 32 gallons were located in a room protected as a hazardous area in 2 of 2 St Paul shower rooms. This deficient practice could affect 6 residents.</p> <p>Findings include:</p> <p>Based on observations with the Property Manager and the Administrator in Training on 03/19/13 from 1:04 p.m. to 1:44 p.m., two forty four gallon soiled linen barrels, approximately one eighth full, were unattended and stored in the St. Paul Birch Street shower room. Additionally, three forty four gallon soiled linen barrels, one completely full, were unattended and stored in the St. Paul Pine Street shower room. Both shower room corridor doors lacked self closing</p>	K010075	26 - 32 gallon soiled linen containers will be purchased to replace all 44 gallon soiled linen containers that are currently being used by the facility. Property Manager responsible Time extension requested to vendors submit quotes sent to Presence Life Connections for approval approved vendor order soiled linen containers Systemic changes will be completed by May 17, 2013	05/17/2013			

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	<p>devices and failed to latch into the door frame. Both shower rooms are considered hazardous areas due to exceeding 32 gallons in a 64 square foot area. Based on an interview with the Administrator in Training at 1:44 p.m., the barrels are stored in the shower rooms until they are taken to the laundry room which occurs three times a day.</p> <p>3.1-19(b)</p>				

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p>	K010144	<p>Monthly checks for generator log form down loaded from LSC website is being utilized to confirm monthly load bank test is meeting or exceeding 30% of the EPS name plate rating for a minimum of 30 minutes. See supporting documentation #2QA to monitor monthly Property Manager responsible Systemic changes completed by April 18, 2013</p>	04/18/2013			

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	<p>Findings include:</p> <p>Based on review of the "Weekly Inspection Checklist Emergency Generator" with the Property Manager on 03/19/13 at 11:19 a.m., the generator test log showed a monthly load test for the past twelve months but the log did not indicate if the diesel generator was exercised under operating conditions, maintains the minimum exhaust gas temperatures or not less than thirty percent of the EPS nameplate rating at least monthly, for a minimum of thirty minutes. Based on an interview with the Property Manager at the time of record review, he stated the generator was exercised above 30 percent of the EPS nameplate rating but was unable to provide documentation for confirmation.</p> <p>3.1-19(b)</p>				

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 of 28 residents in St. Anthony.</p> <p>Findings include:</p> <p>Based on an observation with the Property Manager on 03/19/13 at 12:34 p.m., an extension cords was plugged in and providing power to an electric skillet and a crock pot in resident room 13 in St. Anthony. Based on an interview with the Property Manager at the time of observation, the facility does not allow the residents to have extension cords or electric skillets.</p> <p>3.1-19(b)</p>	K010147	<p>Extension cord removed from resident room #13 on St Anthony. A walk through will be completed in all resident areas to ensure no extension cords are currently being used. Environmental checklist updated to ensure no extension cords are being utilized throughout the facility. See attached supporting documentation #3QA to monitor monthly Property Manager responsible Systemic changes completed by April 18, 2013</p>	04/18/2013

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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155512		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED  03/19/2013	
NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710			
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K030000	<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: 03/19/13</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Presence Sacred Heart Home 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) and 410 IAC 16.2. The new section of the building consisting of the H wing was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K030000					

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	<p>corridors, areas open to the corridors and hard wire smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 117 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710			
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K030144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p>	K030144	<p>Monthly checks for generator log form down loaded from LSC website is being utilized to confirm monthly load bank test is meeting or exceeding 30% of the EPS name plate rating for a minimum of 30 minutes. See supporting documentation #2QA to monitor monthly Property Manager responsible Systemic changes completed by April 18, 2013</p>	04/18/2013			

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	<p>Findings include:</p> <p>Based on review of the "Weekly Inspection Checklist Emergency Generator" with the Property Manager on 03/19/13 at 11:19 a.m., the generator test log showed a monthly load test for the past twelve months but the log did not indicate if the diesel generator was exercised under operating conditions, maintains the minimum exhaust gas temperatures or not less than thirty percent of the EPS nameplate rating at least monthly, for a minimum of thirty minutes. Based on an interview with the Property Manager at the time of record review, he stated the generator was exercised above 30 percent of the EPS nameplate rating but was unable to provide documentation for confirmation.</p> <p>3.1-19(b)</p>				