

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 06/20/2013
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME INC	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: 06/20/13</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 Inc. 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 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, Pathways 2, and Pavilion. The facility</p>	K010000	Please accept this Plan of Correction as our credible allegation of compliance. This Plan of Correction is submitted as part of the regulatory required response and is not to be construed as agreement with the deficiencies cited.	
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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>was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, both basements, and in all resident sleeping rooms. The facility has a capacity of 212 and had a census of 173 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, one plastic shed used for bio hazard waste, and the elevator equipment room in the main basement.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/28/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 kitchen service metal rolling doors were held open only by devices arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect up to 71 residents as well as staff and visitors from the 500 and 600 halls while in the main dining room, and up to 26 residents, as well as staff and visitors while in Pathways 1.</p> <p>Findings include:</p> <p>a. Based on observation on 06/20/13 at 12:40 p.m. during a tour of the facility with the Director of Environmental Services and the Maintenance Supervisor, the metal rolling service door between the Pathways 1 kitchen and the corridor was</p>	K010021	No residents were found to be affected to date by the cited deficient practice. So that there will be no opportunity for possible harm to residents in the future until such corrections are made, a monitoring system has been put into place to insure that residents are removed, according to our fire plan already in place, from the area if a fire monitoring device is activated. In addition, the roll-down door is never open unless dietary staff is present. Dietary staff will sign off on a newly instituted log sheet to verify the presence of dietary staff when the roll-down doors are open in the Main Kitchen/Dining Room and the Pathways I Kitchen/Dining Room [Exhibits B & C].The Director of Environmental Service/designee will monitor the dietary roll-down windows while open during meal	07/26/2013			

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	<p>not provided with a self closing device and was only able to be opened and closed manually with a metal bar located next to the metal rolling door. Based on interview at the time of observation, the Director of Environmental Services and the Maintenance Supervisor acknowledged the metal rolling door between the Pathways 1 kitchen and the corridor was not provided with a self closing device, plus, they stated the metal rolling door had to be manually opened and closed with a metal bar.</p> <p>b. Based on observation on 06/20/13 at 1:18 p.m. with the Director of Environmental Services and the Maintenance Supervisor, the metal rolling service door between the kitchen and main dining room was held open with a chain and fusible link which did not allow the door to close automatically when the fire alarm system was activated. Based on interview at the time of observation, the Director of Environmental Services and the Maintenance Supervisor acknowledged the metal rolling door between the kitchen and main dining room was held open with a chain and fusible link which did not allow the door to close automatically when the fire alarm system was activated.</p> <p>3.1-19(b)</p>		<p>times. Contractors have been hired to install a replacement metal door in the Pathways I food service area. The new door will be automatic and will be connected to the fire alarm system. Activation for the automatic door will occur at any time the fire alarm system in that zone has been activated, either by smoke detector or by manual activation of the fire alarm system. Additionally, automation of the roll-down door in the main kitchen has been reconfigured so that the activation of any device in that zone will trip the door and release it to closed position. Contractors' names and phone numbers are available upon request. The functionality of the automatic roll-down doors will be monitored quarterly by the fire alarm and sprinkler inspector. Any issue will be corrected immediately. As well, a quality assurance performance improvement program was implemented under the supervision of the Director of Environmental Services. Any deficiencies will be corrected immediately, and the results of the monitoring will be brought to the monthly Quality Assurance Performance Improvement Committee for further review, analysis, corrective action and recommendations for six (6) months.</p>				

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K010046 SS=C	<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 record review, interview and observation; the facility failed to ensure the documentation for the testing of 33 of 33 battery powered light sets was complete when testing monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Emergency Battery Light documentation on 06/20/13</p>	K010046	<p>No residents were found to be affected to date by the cited deficient practice, and no residents were identified as having potential to be affected. A new form has been created to assist in the monitoring of the 33 battery-operated emergency lights (Attachment "A"). This form will be used, along with the existing computer-based tracking system that has been conducted for several years on a monthly basis by the maintenance staff. The newly created form will be kept by the Director of Environmental Services and will be monitored for compliance of the 30-second monthly testing and the 90-minutes yearly testing for each of the 33 battery-operated emergency lights. Any deficiencies will be corrected immediately, and the results of the monitoring will be brought to the monthly Quality Assurance Performance Improvement Committee for further review, analysis, corrective action and recommendations for six (6) months.</p>	07/10/2013			

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	<p>at 11:15 p.m. with the Director of Environmental Services and the Maintenance Supervisor present, there was documentation to show the 33 battery backup light sets in the facility had been tested monthly for thirty seconds and a ninety minute annual test within the past twelve months, however, it was a blanket statement each month which did not include an itemized list of each battery backup light set. Based on observation during a tour of the facility, all 33 battery backup light sets did function properly. This was confirmed by the Director of Environmental Services and the Maintenance Supervisor at the time of record review and during a tour of the facility.</p> <p>3-1.19(b)</p>				

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	<p>Based on observation on 06/20/13 at 11:40 a.m. during a tour of the facility with the Director of Environmental Services and the Maintenance Supervisor, the elevator equipment room in the main basement was not provided with sprinkler coverage. This was acknowledged by the Director of Environmental Services and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>to the introduction of water in the elevator equipment room. Termination of electric power will only take place upon the activation of sprinkler heads located in the elevator equipment room, as per ASME [American Society of Mechanical Engineers] / ANSI [American National Standards Institute] A.17.1. Contractors' names and phone numbers are available upon request. A quality assurance performance improvement program was implemented under the supervision of the Director of Environmental Services. Any deficiencies will be corrected immediately, and the results of the monitoring will be brought to the monthly Quality Assurance Performance Improvement Committee for further review, analysis, corrective action and recommendations for six (6) months.</p>		