

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/05/2012
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NAME OF PROVIDER OR SUPPLIER  SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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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
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K0000	<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: 12/05/12</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 1002752200</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee.</p> <p>At this Life Safety Code survey, Simmons Loving Care Health Facility was found not in compliance with Requirements for Participation in 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</p>	K0000		
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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>and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. Twenty resident rooms were provided with battery operated smoke detectors. The facility has a capacity of 46 and had a census of 25 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed in the supervisor room and the conference room. This deficient practice could affect the residents in the west wing.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/05/12 with maintenance worker # 1 during the tour from 9:00 a.m. to 11:30 a.m., there was paneling on the walls in the supervisor room and in the conference room. Interview with maintenance worker # 1 at the time of observation indicated documentation was not available to demonstrate the paneling was provided with a flame spread rating of Class A or B, or had been treated with flame retardant material.</p>	K0015	<p>According to the lawsuit filed by Indiana State Board of Health v/s Simmons Loving Care Health Facility which has mandated the facility to install a fire sprinkler system by 1/31/2013 the area panel was however sprayed with a flame retardant solution. The paneling on the walls in the supervisor room and in the conference room. The date flame retardant solution was applied along with type of flame retardant solution used and area applied documentaion will be kept in the maintanence log book.</p>	01/31/2013	

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	3.1-19(b)			

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K0019 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Vision panels in corridor walls or doors are fixed window assemblies in approved frames. (In fully sprinklered buildings, there are no restrictions in the area and fire resistance of glass and frames.) 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure vision panels in one of three unsprinklered emergency exit corridors consisted of fixed wired glass, or fire rated glass, in approved frames. This deficient practice could affect the residents in the west wing.</p> <p>Findings include:</p> <p>Based on observation on 12/05/12 with maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., the secretary and the administrator office corridor windows consisted of one nonwired glass panel in a three by five foot wood frame. In addition, the maintenance supervisor's office double glass doors were not fixed wired or fire rated glass. Interview with maintenance worker # 1 indicated at the time of observation, there was nothing to show the glass was fire rated as required.</p> <p>3.1-19(b)</p>	K0019	<p>According to the lawsuit filed by Indiana State Board of Health v/s Simmons Loving Care Health Facility which has mandated the facility to install a fire sprinkler system by 1/31/2013 the area will be sprinklered and there will be no need to further respond to the vision panel windows in the secretary and administrator office corridor, nurses station hallway, east and west wing hallway and front entrances. The areas discussed have been this way since the construction of the facility in 1968 - 1970.</p>	01/31/2013	

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K0038 SS=E	<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 1 of 1 magnetically locked exit doors was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>This deficient practice could affect any residents, staff and visitors using the main entrance.</p> <p>Findings include:</p>	K0038	<p>According to the lawsuit filed by Indiana State Board of Health v/s Simmons Loving Care Health Facility which has mandated the facility to install a fire sprinkler system by 1/31/2013 along with a digital fire alarm system which will cause all magnetically locked exit doors accessible for all residents, staff and visitors. The new system installed will allow the doors unlock upon actuation automatic sprinkler system and upon the actuation of smoke detectors. The doors will also unlock upon loss of power controlling the lock or locking mechanism.</p>	01/31/2013			

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	<p>Based on observation and interview on 12/05/12 with maintenance supervisor at 3:30 p.m., the east door of the main entrance set of double exit doors was provided with a magnetic lock, but it did not release when the fire alarm was activated and it kept the other door from opening also. This was acknowledged by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p>			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on interview, the facility failed to provide emergency forces notification in accordance with LSC 9.6.4. LSC 9.6.4 requires the fire alarm system to be arranged to transmit the alarm automatically and in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 5-2.6.1 requires alarm signals initiated by manual fire alarm boxes, automatic fire detectors, water flow from the automatic sprinkler system, or actuation of other fire suppression system(s) or equipment shall be treated as fire alarms.</p>	K0051	<p>According to the lawsuit filed by Indiana State Board of Health v/s Simmons Loving Care Health Facility which has mandated the facility to install a fire sprinkler system by 1/31/2013. A new digital fire alarm system has been installed which provides emergency forces notification to transmit the alarm automatically. It requires alarm signals initiated by manual fire alarm boxes, automatic fire detectors, water flow from the automatic sprinkler system, or actuation of fire suppression system or equipment shall be treated as fire alarms. The central station shall perform the following actions:(1) Immediately retransmit the alarm</p>	01/31/2013			

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	<p>The central station shall perform the following actions:</p> <p>(1) Immediately retransmit the alarm to the public fire service communications center</p> <p>(2) Dispatch a runner or technician to the protected premises to arrive within 1 hour after receipt of a signal if equipment needs to be manually reset by the prime contractor</p> <p>(3) Immediately notify the subscriber</p> <p>(4) Provide notice to the subscriber or authority having jurisdiction, or both, if required</p> <p>Exception: If the alarm signal results from a prearranged test, the actions specified by 5-2.6.1.1(1) and (3) shall not be required.</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on interview with the alarm company dispatcher on 12/05/12 at 3:38 p.m., the dispatcher indicated the monitoring company contacts the facility first after the fire alarm activation is received and if the facility does not respond, the fire department is dispatched.</p>		<p>to the public fire service communications center(2) Dispatch a runner or technician to the protected premises to arrive within 1 hour after receipt of a signal if equipment needs to be manually reset by the prime contractor(3) Immediately notify the subscriber(4) Provide notice to the subscriber or authority having jurisdiction, or both, if required with the exception: If the alarm signal results from a prearranged test, the actions specified shall not be required.</p>				

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	Based on interview, this procedure was confirmed by the maintenance supervisor at 4:00 p.m. on 12/05/12. 3.1-19(b)			

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 11 of 11 smoke detectors had been tested for sensitivity every two years. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. NFPA 72, National Fire Alarm Code at 7-3.2 requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(i) refers to 7-3.2.1 which requires Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To</p>	K0052	<p>F 0052 Point of Clarification: After interview with staff I was informed that information was located in the binder. Smoke detector sensitivity test was done on 10/29/12. A 5 page report was available for review for the surveyors. Enclosed is a copy of the report. A new digital fire alarm system is scheduled for installation because of the mandated fire sprinkler system. Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a</p>	01/31/2013			

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	<p>ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 from 9:30 a.m. to 11:30 a.m. with maintenance worker # 1, the facility</p>		<p>maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:(1) Calibrated test method(2) Manufacturer's calibrated sensitivity test instrument(3) Listed control equipment arranged for the purpose(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range(5) Other calibrated sensitivity test methods approved by the authority having jurisdictionDetectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and</p>	

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	<p>had two reports titled, "Initiating/Supervisory Test &amp; Inspection Report" dated 08/15/11 and 10/29/12. Both forms had a column titled functional test. Each smoke detector had a numerical value listed under functional test. A sensitivity range for each smoke detector was not listed on the form. Based on an interview with maintenance worker # 1 there are no other records available for review to indicate the test had been conducted.</p> <p>3.1-19(b)</p>		<p>recalibrated or be replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Addendum: Digital Fire Alarm System required an additional \$45,000.00 of expense it includes new smoke detectors, pull stations, etc. with a new fire alarm panel. Nothing from the previous fire alarm system will remain. Battery operated smoke detectors will remain same areas.</p> <p>Therefore no calibration will be performed until 2014, 2016 and 2021 or unless the guidelines change.</p>		

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K0053 SS=F	<p>NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 20 of 20 single station smoke detectors would operate. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 from 9:30 a.m. to 11:30 a.m. with maintenance worker # 1, the Preventive Maintenance Book did not have documentation indicating a battery replacement program for the twenty single station smoke detectors in resident rooms. Based on an interview with maintenance worker # 1 at the time of record review, there is no documentation for the replacement of single station smoke detector batteries.</p> <p>3.1-19(b)</p>	K0053	<p>All 20 of 20 single station smoke detectors operated properly during tour. All batteries are replaced during the fall of the year when time falls back and during the spring when time springs ahead and as needed.</p> <p>MONTHBATTERY CHECKEDBATTERY REPLACED JAN FEB MAR APRIL MAY JUNE</p> <p>Preventive Maintenance Book has been updated. New maintenance staff has been inserviced and log book will be monitored by supervisor semi-annually.</p>	01/03/2013			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/05/2012
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K0066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <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 observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect any staff utilizing the designated employee smoking area adjacent to the resident dining area exit during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation and interview on</p>	K0066	F0066 Signs have been posted at front and back entrance and exit doors. The sign states no smoking within 8 feet of entrance pursuant to the Indiana Smoke free Air Law. Employees have been in-serviced on proper smoking areas. Areas are monitored each day by custodial staff. The facility had 2 noncombustible containers for cigarette disposal however both containers were thrown away. We have had a lot of construction workers at the facility and we are not able to figure out who discarded the containers. 2 new	01/05/2013	

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	<p>12/05/12 with maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., there were discarded cigarette butts by the exit door of the kitchen on the west side of the facility. Based on interview on 12/05/12 with maintenance worker # 1 concurrent with the observations, maintenance worker # 1 acknowledged the facility's employees disposed of cigarette butts on the ground. The maintenance worker acknowledged the facility is a nonsmoking facility.</p> <p>3.1-19(b)</p>		<p>containers have been ordered and will be received within 1 week. Custodian staff will monitor area daily and supervisor will monitor weekly.</p>		

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K0068 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the basement.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/05/12 with maintenance worker # 1 at 12:18 p.m., the basement laundry room had three fueled fired residential type dryers with no fresh air intake. This was acknowledged by maintenance worker # 1 at the time of observation.</p> <p>3.1-19(b)</p>	K0068	<p>There is an intake air vent connected to laundry rooms for outside air exchange. Maintenance worker showed surveyor the window and cool air could be felt coming in. A exhale fan is located on the roof which vents the carbon monoxide out of the building. The facility is equipped with carbon monoxide detectors. Maintenance worker # 1 offered to show the surveyor the roof top exhaust but they never went to the roof. Surveyor stated that it should not make that much difference becuse they were household dryers.</p>	12/05/2012			

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K0069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure commercial kitchen fire suppression coverage was maintained for the oven covered by the Ansul system. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations at 1.3.1 requires cooking equipment shall be maintained per the standard including the fire suppression system during all periods of operation of the cooking equipment. This deficient practice affects occupants of the kitchen where 2 staff worked.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 with maintenance worker # 1 from 2:00 p.m. to 4:00 p.m., there was no documentation provided showing maintenance of the fire suppression system over the cooking equipment. Based on interview on 12/05/12 with maintenance worker # 1 concurrent with the record review, maintenance worker # 1 acknowledged that there was no documentation available showing maintenance of the fire suppression system over the cooking equipment.</p> <p>3.1-19(b)</p>	K0069	<p>F0069 Fire Science Techniques inspected commercial kitchen fire suppression system for the oven Ansul system on 1/2/2013 and will be inspected semi-annually. Inspection log will be checked semi-annually by supervisor to ensure compliance.</p>	01/02/2013			

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure a minimum distance of at least twenty feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 8-3.1.11.2(c)(1) requires oxidizing gases such as oxygen shall be separated from combustibles or incompatible materials by a minimum distance of twenty feet. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/05/12 during the tour of the facility with maintenance worker # 1 from 2:00 p.m. to 4:00 p.m., ten to fifteen oxygen cylinders were in a room located in the rear portion of the facility with exterior access only. Combustible items such as</p>	K0076	All Oxygen tanks in outside shed were punctured and some bottoms were cut off for scrap disposal. Empty oxygen tanks were not combustible. Metal scrap was picked up by recycle center.	12/05/2012			

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	<p>four bags of wood mulch and two patio umbrellas were stored in this five by five foot nonsprinklered room directly on top of or next to ten to fifteen oxygen cylinders. Based on interview at the time of observation, maintenance worker # 1 acknowledged combustible materials were stored with the oxygen cylinders but indicated the facility did not have any residents on oxygen and he did not know if the cylinders were empty or full.</p> <p>3.1-19(b)</p>			

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K0130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 2 of 3 service water heaters (SWH) had unexpired certificates of inspection. LSC 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 affects all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 with maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., certificates of inspection were not posted for boilers #292903, and #197292. Certificates of inspection kept in a binder in the maintenance office were reviewed with maintenance worker # 1 on 12/05/12 and each had expired on 05/21/12 and 02/25/10. In an interview with maintenance worker # 1 at the time of record review, he acknowledge the boilers had not been reinspected.</p> <p>3.1-19(b)</p>			K0130	<p>All service water heaters were inspected on 10/23/2012 by Indiana Department of Homeland Security. Certificate of inspections are available and posted in boiler room and in log book. Certificate expiration date is 10/23/2014. Certificates of inspection will be reviewed annually by supervisor.</p>		01/08/2013

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K0144 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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This</p>	K0144	<p>F Tag K 144 Waiver Requested until repairs or replacement completed.1 The generator log includes start time, end time, manual or automatic start, rated load, amps, time of transfer power delay, battery operative, oil in motor, emergency lights operative, heating operative, refrigeration operative, run time and reset generator switch. The surveyor did not ask the maintenance staff anything about the generator and his sheets were in the book and up to date.2. Currently generator is having maintenance work completed due to a power surge from NIPSCO. It is being evaluated if the generator can be repaired or replaced. 3. After repairs are complete the generator will be started manually by the custodial/maintenance staff and has an automatic starts</p>	01/05/2013

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	<p>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 with maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., the load tests for the emergency generator were conducted weekly, with the months of November of 2011 and November of 2012 having the generator run for 15 minutes or less. Based on interview at the time of record review, maintenance worker # 1 stated he was not aware of the requirements.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries,</p>		<p>on Saturdays. An In- Service was held with the custodian staff and the generator log was updated on their duties. In-Service was also held with the entire custodial and maintenance staff. 4. The generator log book will be kept by the custodial/maintenance staff. The administrative designee will monitor monthly the generator log sheets for 3 months then quarterly thereafter. The administrator will review the log sheets monthly times 3 months and semi-annually thereafter.</p>				

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	<p>including electrolyte levels, at intervals of not more than 7 days. 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 by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 12/05/12 with maintenance worker # 1 during the tour from 9:00 a.m. to 11:30 a.m., the last documented weekly battery inspection was on 01/10. Additionally, per interview during the record review with maintenance worker # 1, there was no other documentation available for review to verify these weekly generator battery inspections were conducted.</p> <p>3.1-19(b)</p>				

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K0147 SS=E	<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 2 of 2 flexible cords such as an extension cord were 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 one resident in resident room 104, and any number of staff and residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/05/12 with maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., a heavy weight extension cord was plugged in and providing power to a power strip in the laundry room for the gas dryers. Another extension cord was providing power to an air mattress in resident room # 104. Maintenance worker # 1 concurrent with the observations and record review, acknowledged there were extension cords in use in the facility.</p>	K0147	<p>F147 C.N.A. placed cord in power surge outlet used for television equipment by mistake. Air mattress was plugged directly into fixed power source. All resident rooms were checked and no other resident rooms affected. Fixed electrical wiring and equipment will be added to in the laundry room for the gas dryers. In-service held with staff about not plugging air mattresses into the surge protectors or extension cords. Custodial staff will monitor weekly during cleaning. Supervisor will monitor monthly.</p>	01/05/2013			

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K0155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 25 of 25 residents, in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p>	K0155	<p>New digital fire alarm system has a battery system back up for 48 hours. Vendor will supply written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for over 48 hours. It will include the following: Requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. Requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. In-service will be held with staff once system is completed and tested by vendor. <b>FIRE WATCH PURPOSE:</b> To establish a plan of action should the fire alarm system or sprinkler system be out of service for more than 4 hours in a 24-hour period. <b>ACCESS:</b> Available in writing at staff stations and comprehended by training of all facility staff.</p>	01/05/2013			

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	<p>Findings include:</p> <p>Based on record review and interview on 12/05/12 with maintenance worker # 1 during the tour from 9:00 a.m. to 4:00 p.m., the fire watch procedure for an out of service automatic fire alarm system was not complete. The procedure lacked the required telephone numbers for the local fire department and the Indiana State Department of Health (317-233-5359). In an interview with maintenance worker # 1, he stated at the time of record review he had no other policy or procedure available to review.</p> <p>3.1-19(b)</p>		<p><b>STAFF:</b> Facility staff trained in Rescue, Alarm, Contain, and Extinguish/ Evacuate (RACE) and the implementation of a facility-wide fire watch.</p> <p><b>DOCUMENTATION:</b> Each tour is recorded with findings noting date time, and staff initials. A fire watch tour is a periodic walking tour of the entire facility by one or more assigned and trained staff. The tour monitors the facility through direct observation of all rooms for possible signs of fire.</p> <p><b>OCCURANCES:</b> Fire alarm system outages or sprinkler system outages can occur during construction, maintenance, renovation, electrical storms or other unplanned events which eliminate part or all of the fire alarm system. Sprinkler systems may also be made inoperable by a variety of planned and unplanned events. 1. Contact the facility administrator, nurse director and maintenance manager when any problems are encountered with the fire alarm system or sprinkler system. (Action: staff) 2. Contact the fire alarm or sprinkler contractor should the maintenance manager be unable to correct the problem. (Action: administrator/nurse director/maintenance manager). Fire alarm or sprinkler contractor shall be on site or on contract until system is repaired, replaced or reinitialized and working. 3. Notify the fire department at (911) that the sprinkler system or fire</p>	
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NAME OF PROVIDER OR SUPPLIER  SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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			<p>alarm system is not working correctly. (Action: administrator/nurse director/maintenance manager).</p> <p>4. If the sprinkler or fire alarm system is inoperable for a time period of more than <u>4 hours in a 24 hour period</u>, notify the Indiana State Department of Health. They can be contacted at <u>(317)233-1325</u>. (Action: administrator/nurse director/maintenance manager).</p> <p>5. Fire watch procedure shall designate facility tours designating wing, floor, or building identifier. (Action: Facility Administrator)</p> <p>6. Fire watch tours shall occur at ¼ hour intervals, 24 hours a day. (Action: Administration)</p> <p>7. Fire watch shall be performed by personnel solely dedicated to the fire watch and no other facility-related activities or events. (Action: Administration)</p> <p>8. A fire watch should check and document the following in all rooms including: Resident rooms (remove smoking materials and extension cords); Dietary and Laundry rooms (remove lint from dryers and soiled linen); Mechanical and Electrical rooms (remove combustible/flammable materials); Fire department access to the facility (remove snow and ice from exits); Fire department access to hydrants, sprinkler connections, standpipes, and fire extinguishers; Exit access, exits and exit discharge are</p>	

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			<p>unobstructed; Storage of combustible or flammable materials shall be in approved containers or designated storage areas; Identify temporary heating devices and have them removed, Fire and Smoke doors closed properly; Machinery unnecessary to be running continuously is turned off; Sprinkler valves shall be open and sealed, gauges indicate normal pressures, and sprinkler heads shall be unobstructed; Construction or renovation work areas shall be monitored continuously. 1. Maintenance staff shall be available on site or on call for equipment emergency shutdown situations. 2. Additional fire extinguishers shall be distributed facility-wide and staff shall be informed of locations.</p> <p style="text-align: center;"><b>FIRE</b></p> <p>In the event a potential fire situation is identified behind a door: 1. <b>Do Not Open Door.</b> 2. Touch door handle and door leaf and verify raised temperature. 3. Smell for smoke or fumes. 4. Implement '<b>RACE</b>' program: <b>Rescue, Alarm, Contain and Extinguish/Evacuate.</b> 5. Rescue/remove residents from immediate danger. 6. Activate a call to local fire department at (911) if the fire alarm is not directly connected to the fire station. 7. Contain fire by shutting doors. 8. Extinguish and/or evacuate area.</p> <p>Approval date 1/5/13 Review date</p>		

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K9999	<p>State Findings;</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic fire sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic fire sprinkler system is not installed throughout the health facility before July 1, 2010, submit before July 1, 2010, a plan to the department for completing the installation of the automatic fire sprinkler system before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure a plan was submitted for the complete installation of a sprinkler system to protect 25 of 25 residents. This deficient practice affects all occupants within the facility.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/05/12 with the administrator and maintenance worker # 1 during the tour from 2:00 p.m. to 4:00 p.m., the facility</p>	K9999	<p>Life safety surveyors are aware of the lawsuit filed by Indiana State Board of Health v/s Simmons Loving Care Health Facility which has mandated the facility to install a fire sprinkler system by 1/31/2013. The facility will have an automatic fire sprinkler system installed by 1/31/2013.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No resident was in danger by not having 2 non-resident areas fire sprinkler protected. C&amp; E Fire Protection completed installation of the system according to the plans previously approved by the Division of Fire and Building Services of the Indiana Department of Homeland Security and it was operational at 3:30p.m. on 1/31/13. Simmons Loving Care Health Facility has always strived to stay in compliance with the rulings of the ISBH since our beginning January 1, 1970. In previous correspondence with ISBH and the Life Safety Department we have explained the delay of installation of the fire sprinkler system for July 1, 2012 due to financial reasons. Simmons Loving Care Health Facility reached an agreement with ISDH for the fire sprinkler system to be installed by January 31, 2013. The plans were</p>	03/03/2013	

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	<p>was not sprinklered and a finalized plan was not available for review which would address the installation of a sprinkler system for the facility. The administrator stated at the time of the interview, she was working on obtaining the finalized plans for the installation and is waiting on the city of Gary to issue a permit.</p> <p>3.1-19(ff)</p>		<p>submitted to the Department of Homeland Security and approved. The facility met with C &amp; E Fire Protection Staff, the Design Engineer and the Gary Fire Chief Inspector on several occasions to ensure we were meeting the NFPA and City of Gary Fire Codes. During construction of the fire sprinkler systems the Gary Fire Chief Inspector and C &amp; E foreman consulted when modifications were needed due to unforeseen steel and concrete barriers. Simmons Loving Care installed a digital fire alarm system with smoke detection and carbon monoxide detectors in the corridors and spaces open to the corridors with battery operated smoke detectors in all resident rooms. The facility has tried to meet all standards for the installation of the fire sprinkler system and fire alarm system and at no time were they aware that the ISBH required that we deviate from the approved plans by installing dry side wall sprinkler heads in 2 non- resident areas. One area is a 5X4 solid concrete and brick construction storage only accessible from the outside of the building and has no inside connection from the interior of the facility. The second area is the walk-in freezer which is in the kitchen and no resident is allowed in that area at any time. On 2/1/13 the constructors from C &amp; E Fire Protection, American Eagle</p>		

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			<p>Fire Alarm and Fire Chief Inspector were awaiting the visit by the Life Safety Surveyors. During the LSS walk through the surveyors stated that the exterior room and walk-in freezers needed protection. It was discussed with LSS that a pre-construction meeting with the Fire Chief Inspector had been held and it was agreed upon that those areas were not required to be fire sprinkler protected since they were not in a heated area. However, we agreed that ISDH is the authority having jurisdiction over our facility and agreed that we would ask the contractor to install heads in these areas. The feeds started to the new heads were immediately started and completed prior to LSS leaving the building and special dry sprinkler heads were ordered on 2/4/13. The heads are custom made and have approximately a 2 week lead time when ordered. C&amp;E Fire Protection will install the 3 heads once received. 2. 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 residents are affected by the 2 areas not having the dry sprinkler heads. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; When dry sprinkler heads arrive they will be installed</p>		

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			by C & E Fire Protection. 4. 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; and by what date the systemic changes will be completed. The facility is in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access are already sprinklered as well as all areas providing facility services. The two noted areas will be fire sprinklered protected once the dry sprinkler heads arrive. The administrator will inform the ISBH and the Life Safety Department after the special sprinkler heads are installed. 5. 3/3/13 date given by ISDH Survey Event ID ISEU21		