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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155519 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 01/08/2014 |
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| NAME OF PROVIDER OR SUPPLIER GENTLECARE OF VINCENNES | STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST VINCENNES, IN 47591 |
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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: 01/08/14</p> <p>Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Gentlecare of Vincennes 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 a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the</p> | K010000 | K000 This plan of correction is submitted to serve as an allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the allegations or conclusions set forth in the statement of deficiencies. GentleCare of Vincennes was in compliance as of 01/24/14 and respectfully request a paper compliance review for the Life Safety Code Survey | |

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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| K010048 SS=F | <p>corridors, and battery operated smoke detectors in all resident sleeping rooms which were also addressable to the fire alarm system via a wireless system. The facility has a capacity of 60 and had a census of 50 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 50 of 50 residents to accurately address all life safety systems such as the use of all types of fire extinguishers in the facility including the K-class fire</p> | K010048 | K048 Corrective Actions for Residents Found to Have Been Affected: The Administrator determined there were no residents affected by this practice. Identification of Residents Having the Potential to be affected: Per ISDH findings all the residents of Gentle Care have | 01/24/2014 | | | |

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| | <p>extinguisher in the kitchen thus addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 01/08/14 at 2:00 p.m. with the Administrator and Maintenance Supervisor present, the Procedure for Person Discovering Fire (fire plan) did not address the type of fire extinguishers provided in the facility including the ABC type located throughout the facility and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Administrator acknowledged</p> | | <p>a potential to be affected. The Fire Plan was revised (1/22/14) to correct this practice. Measures or Systemic Changes to Prevent Reoccurrences: The Fire Plan (Attachment A) was revised to include the information necessary to locate and operate fire extinguishers throughout the facility. The Fire Plan was revised to include information necessary to locate and operate the kitchen fire extinguishers and the kitchen an sul system. All staff were in-serviced on the revised Fire Plan, RACE and PASS (Attachment B) on 01/23/14. All staff will be in-serviced monthly on the revised Fire Plan along with RACE and PASS. All staff will be in-serviced annually on the use of extinguishers with a local fire department representative conducting the in-service and staff will be able to practice using fire extinguishers. Corrective Action Monitored: The Administrator will review the Fire Plan monthly to determine its effectiveness with results of this review reported to the facility Continuous Quality Improvement Committee (CQI). The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The committee is responsible</p> | | |

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| K010052 SS=C | <p>the fire plan did not address the use of all types of fire extinguishers in the facility.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to ensure the documentation for the sensitivity testing of 34 of 49 smoke detectors was complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused</p> | K010052 | <p>for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p> <p>Corrective Actions for those Residents found to have been affected: The Administrator determined there were no residents found to have been affected. Identification of Residents having the Potential to be affected: Per ISDH findings all residents as well as staff and visitors of Gentle Care have the potential to be affected. To correct this practice smoke detectors in all resident rooms were tested by a Calibrated Test Method (01/20/14) Measures or Systemic Changes to Prevent Reoccurrences: Smoke detectors in residents rooms will be tested by a Calibrated Test Method and the results recorded on the "Smoke Detector Sensitivity Test</p> | 01/24/2014 | |

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| | <p>nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (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 acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain</p> | | <p>Report (Attachment C). The Sensitivity testing will be done every alternative year and results recorded on the "Smoke Detector Sensitivity Test Report." This report will be maintained for the life of the system and available for examination. Corrective Action Monitored: Maintenance will provide the "Smoke Detector Sensitivity Test Report" (Attachment C) to the Administrator for review each year the tests are completed. The Administrator will report the results of sensitivity testing to the Continuous Quality Improvement Committee (CQI). The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The committee also assists in the development and initiation of plans of correction related to identify problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p> | | | | |

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| | <p>these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/08/14 at 12:15 p.m. with the Maintenance Supervisor present, the biannual smoke detector sensitivity testing report dated 09/27/12 did include a sensitivity range for each smoke detector, however, there was not a sensitivity alarm point included for 34 of 49 smoke detectors, furthermore, all smoke detectors were marked as "Pass" on the report. The 34 smoke detectors without a documented sensitivity alarm point were located in all resident sleeping rooms. During an interview at the time of record review, the Maintenance Supervisor acknowledged there was no documented alarm point on the sensitivity testing report dated 09/27/13.</p> <p>3-1.19(b)</p> | | | | |