

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 303 NOTRE DAME, IN 46556
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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: 06/05/14</p> <p>Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Holy Cross Village at Notre Dame 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 a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the</p>	K010000	<p>Holy Cross Village at Notre Dame Inc., (the "Provider") submits this plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by then Centers for Medicare and Medicaid Services, ("CMS"), the state of Indiana or any other entity; or (2) serve, in anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010062 SS=C	<p>Quinn Wing, which is a noncertified comprehensive care unit, in 2007. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 48 and had a census of 42 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered exit. All areas which provide facility services are sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/14.</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 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure quarterly</p>	K010062	<p>that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on June 5, 2014. We respectfully ask for a desk review and opportunity for paper compliance.</p> <p>We found no residents, staff, or visitors were affected by this</p>	06/20/2014

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	<p>sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.6 requires alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 2-3.3 requires waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Kropp Fire Protection, Inc. "Report of Inspection" documentation dated 03/14/13, 07/02/13, 09/18/13, 12/31/13 and 03/18/14 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:00 p.m. on 06/05/14, the second quarter (April, May, June) 2013 sprinkler system inspection report was not available for review.</p>		<p>deficiency. Holy Cross Village will work with a contractor to stay within the quarter. The Director of Plant Operations will monitor and audit (attachment #3) compliance of dates and inspection with regard to sprinkler inspections. Director of Plant Operations will report audit results quarterly to the CQI committee for one year. Director of Plant Operations will be responsible for the correction of this deficiency. The deficiency will be corrected by June 20, 2014.</p>	

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K010069 SS=D	<p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:30 p.m. on 06/05/14, calendar quarter sprinkler inspection tags affixed to the sprinkler system riser in the basement mechanical room did not document a second quarter 2013 inspection. Based on interview at the time of record review and of observation, the Maintenance Supervisor acknowledged the second quarter 2013 sprinkler system inspection report was not available for review.</p> <p>3.1-19(b)</p> <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 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust</p>	K010069	<p>Upon review, no residents, staff, or visitors were affected by this deficient practice. The hood was cleaned on March 3, 2014 with a new certified contractor. The new contractor is scheduled to clean on September 14, 2014. A monthly inspection sheet (attachment #3) will be changed to include visual inspection of hood for grease and sludge build up as well as check due date to</p>	06/18/2014

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	<p>System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Facilities Management LLC "Inspection Sheet" documentation dated 01/09/2013 and Koorsen Fire & Security "Restaurant Systems Work Order" documentation dated 03/03/14 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:00 p.m. on 06/05/14, documentation of a semiannual kitchen exhaust systems inspection six months after 01/09/13 was not available for review. Based on interview at the time of</p>		<p>monitor semiannual cleaning by certified contractor. CQI will monitor every quarter for two (2) years and thereafter semiannually. The Director of Plant Operations will audit hood cleaning schedule to assure compliance on semiannual basis. Director of Plant Operations will report to CQI committee every quarter for two (2) years and then semiannually thereafter until compliance has been achieved. This deficiency will be corrected as of June 18, 2014.</p>	

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K020038 SS=E	<p>record review, the Maintenance Supervisor stated a semiannual kitchen hood system inspection after the January 2013 inspection was not performed and acknowledged documentation of semiannual kitchen exhaust systems inspection six months after 01/09/13 was not available for review.</p> <p>3.1-19(b)</p> <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 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says 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, or an approved, supervised automatic sprinkler system</p>	K020038	<p>Upon review, no residents, staff, or visitors were affected by this deficient practice. A permanent sign has been installed clearly stating "push until the alarm sounds door can be opened in 15 seconds" (attachment #1). The door was tested and functioned properly. A four (4) digit code has been posted on the code alert box (attachment #2). Monthly inspection sheet (attachment #3) will include testing of the 15 second release of the door, 15 second delay sign, and code is posted on the box. Any deficiencies will be corrected</p>	06/19/2014

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	<p>installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 10 residents, staff and visitors in the Murphy Wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the</p>		<p>immediately. The Director of Plant Operations will report to CQI Quarterly for one (1) year and then semiannually thereafter until compliance has been achieved. The deficiency will be corrected by June 19, 2014.</p>	

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	<p>Administrator during a tour of the facility from 12:45 p.m. to 3:30 p.m. on 06/05/14, the exit door in the Murphy Wing by Room 102 to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock but is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. In addition, the exit door did not release within 15 or 30 seconds when the door was pushed with the application of force two separate times. Based on interview at the time of observation, the Maintenance Supervisor stated the aforementioned exit door is a facility exit, is equipped with a delayed egress lock and acknowledged the exit door by Room 102 did not release within 15 seconds and did not have signage posted indicating the door would release when pushed with the application of force.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the</p>			

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	<p>egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 10 residents, staff and visitors in the Murphy Wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Administrator during a tour of the facility from 12:45 p.m. to 3:30 p.m. on 06/05/14, the exit door in the Murphy Wing by Room 102 to the exterior of the building is marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Administrator stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at the exit by Room 102. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-19(b)				