

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
--------------------	--	---------------	---	----------------------

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: 11/19/13</p> <p>Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Newburgh Health Care 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 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 and in spaces open to the corridors, plus battery operated smoke detectors in all resident</p>	K010000	Preparation and or execution of this Plan of Correction general, or any other corrective action set forth herein, in particular, does not constitute an admission by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed solely because of provisions of State and Federal law.	
---------	--	---------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630
--	--

(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
	<p>sleeping rooms. The facility has a capacity of 114 and had a census of 108 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage were sprinklered, except a small detached wood framed shed used for furniture storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/20/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2013	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630			
(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			
K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 3 of 4 quarters, furthermore, the facility failed to provide complete documentation for 3 of 11 fire drills. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills book on 11/19/13 at 10:55 a.m. with the Maintenance Supervisor present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <p>a. The first shift (day) of the fourth quarter (October, November, and December) of 2012.</p> <p>b. The third shift (night) of the second quarter (April, May, and June) and third quarter (July, August, and September) of</p>	K010050	<p>I. The fire drill documentation noted in the Statement of Deficiencies is unable to be corrected.II. All residents have the potential to be affected.III. The fire drill policy and procedure has been reviewed and revised to ensure drills are held at least quarterly on each shift. Fire drills will be conducted one time per month on all shifts at varying times. Documentation of the fire drill will be documented on the facility fire drill form. The Staff development Coordinator will be responsible for ensuring that documentation is completed and noted on the facility fire drill form.IV. The staff Development Corrdinator will monitor monthly on an ongoing basis. The facility administrator will monitor monthly for three months. The results of the monitors will be entered into the monthly QAPI meetings for review and to determine if additional fire drills are necessary.V. Date of completion is 12/19/13</p>	12/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2013
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 POLLACK AVE NEWBURGH, IN 47630		
(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	
	<p>2013.</p> <p>Furthermore, fire drill documentation for 08/02/13, 09/21/13, and 10/15/13 was not complete. All three fire drills were not on the facility's normal fire drill form, they were on a blank paper which only included the date and staff signatures. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>				