

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2012
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NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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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: 06/08/12</p> <p>Facility Number: 011045 Provider Number: 155698 AIM Number: 200380790</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bethany Pointe Health Campus 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 NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original portion of the facility built in 1999, building 01, consists of everything except 600 wing and was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The one story facility was determined to be Type V(111) construction and fully sprinklered (except for 27 of 28 resident room closets on 100 hall east and west).</p>	K0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the acts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respons to the allegation of noncompliance cited during the Annual Life Safety survey of 6-8-2012. Please accept this Plan of Correction as the provider's credible allegation of compliance. The Provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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	<p>The facility was surveyed as two separate buildings due to the construction dates of the two sections of the building. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 62 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/18/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observations and interview, the facility failed to ensure 3 of 3 sets of Dining room corridor doors on North wing and 1 of 1 Therapy corridor doors would latch into their frames and had no impediments to closing. This deficient practice could affect 12 residents on South wing which is adjacent to the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/08/12 at 1:20 p.m. with the Maintenance Supervisor, the following doors would either not latch into their frame or were held open with a metal doorstop:</p> <p>1. The North, South and East dining room corridor door sets would not latch into their door frames and were held open</p>	K0018	<p>Corrective action to be accomplished for those residents found to be affected by the alleged deficient practice: The glass surrounding the dining area does not constitute a smoke barrier wall. Therefore the doors entering the dining area have been removed to permit un-restricted access to this area. The door to the therapy area will have a magnetic door holder installed which will be tied in with the fire alarm system and will close when the alarm sounds. The metal doorstop has been removed. How will other resident having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken: All residents entering and leaving the dining room and the therapy area have the potential to be affected by this alleged deficient</p>	07/13/2012			

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	<p>with metal doorstops.</p> <p>2. The Therapy corridor door on north hall was held open with a metal doorstop. Based on interview on 06/08/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned doors would not latch into their frames and were held open with metal doorstops.</p> <p>3.1-19(b)</p>		<p>practice. The glass surrounding the dining room area does not constitute a smoke barrier wall. Therefore the doors entering the dining area have been removed to permit un-restricted access to this area. The door to the therapy area will have a magnetic door holder installed which will be tied in with the fire alarm system and will close when the alarm sounds. The metal door stop has been removed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Plant Ops Director or his designee will monitor the entrances into the dining room to ensure they remain un-restricted for free access. The therapy door will be audited for complete closing on a daily basis times 7, weekly thereafter for 6 months and randomly when the fire alarm activates to ensure substantial compliance is achieved. How will the corrective action be monitored to ensure the alleged deficient practice does not recur: A Quality Assurance monitor will be developed to document the audits and will be reviewed at the monthly Quality Assurance and Safety meeting to ensure doorways in the dining room remain un-restricted and readily accessible to residents; and that the therapy door closes properly when the fire alarm sounds. Director Plant Ops/Executive</p>		

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observations and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always closes first so both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors that swing in the same direction and are equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 49 residents on 100 east and west hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/08/12 at 12:30 p.m. with the Maintenance Supervisor, the set of smoke barrier doors leading into 100 hall west swung in the</p>	K0027	<p>What corrective action will be accomplished for those residents affected by the alleged deficient practice: A mechanical coordinator has been installed to ensure the astragal side of the door will consistently close last. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: All resident in the 100 West wing and the 600 East wing have the potential to be affected by the alleged deficient practice. The mechanical coordinator installation was initiated immediately and was fully operable by 6-22-2012. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Plant Ops Director or his designee will visually observe the closing of these doors to ensure the mechanical coordinator is working properly and that the</p>	07/13/2012			

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	<p>same direction, were equipped with a metal astragal, but lacked a coordinator to allow the astragal side of the door to close first. When tested, these sets of smoke doors closed properly with the astragal door closing first. Based on interview on 06/08/12 at 12:33 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier doors lacked a coordinator to ensure the door with the metal astragal always closed first.</p> <p>3.1-19(b)</p>		<p>astragal side of the door closes last on a weekly basis times 4, then monthly times 6 months. The doors will continue to be checked during the monthly fire drills thereafter. In addition, the fire service provider will check the closing of the doors quarterly during the routine fire inspection. How the corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool will be used to document the door audits and the results of the audits will be reviewed at the monthly Quality Assurance Committee Meetings, times 6 months, for further recommendations. Date completed: 7/13/2012</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 doors leading to hazardous areas such as a kitchen would latch into its frame and be smoke resistant. This deficient practice affects 8 residents observed in the adjacent main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/08/12 at 2:00 p.m. with the Maintenance Supervisor, the kitchen door would not latch into its frame. Furthermore there was a one half inch gap at the top of the door and a one and one half inch gap on the hinge side of the door which would not resist the passage of smoke. Based on interview on 06/08/12 at 2:03 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door</p>	K0029	<p>What correction action will be accomplished for those residents found to be affected by the alleged deficient practice: The swinging door coming from the kitchen to the main dining room will be replaced with a 1 hour fire rated, smoke resistant door and equipped with a latching device. How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken: All residents who take their meals in the main dining room as well as staff and visitors have the potential to be affected by the alleged deficient practice. The swinging door from the kitchen will be replaced with a 1 hour fire rated, smoke resistant door and equipped with a latching device. The replacement door has been ordered and will be installed at soon as it arrives. What measures will be put into place or what systemic changes will be made to ensure that the</p>	07/13/2012	

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	<p>leading into the kitchen was not equipped with a latching device and was not smoke resistant when the door was closed.</p> <p>3.1-19(b)</p>		<p>deficient practice does not recur: The Plant Ops Director or his designee will check for closure of the new door daily times 7, then weekly times 4, then monthly times 6 months to ensure the door is not propped open with a mechanical device at any time. How the corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance audit tool will be developed for use when checking the door. The Audits will be reviewed at the monthly Quality Assurance Committee meeting for 6 months for further recommendations and will continue until full compliance is achieved.</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 27 of 28 resident room closets on 100 east and west hall were provided with automatic sprinkler heads to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 49 residents as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 06/08/12 during the tour between 12:17 p.m. to 3:00 p.m. with the Maintenance Supervisor, resident rooms 100 to 114 and 116 to 127 were not provided with sprinkler head coverage. Based on interview on 06/08/12 concurrent with each observation with the Maintenance Supervisor, it was acknowledged there were no sprinkler heads present in the</p>	K0056	<p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice: Automatic sprinklers will be installed in all the closets on the 100 east and west halls to ensure sprinkler coverage in all portions of the building. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: All residents, staff and visitors in the facility have the potential to be affected by this alleged deficient practice. Arrangements have been made with a service provider to instaff sprinklers in the closets on the 100 east and west halls at the earliest time possible. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Plant</p>	07/13/2012

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	aforementioned resident room closets to provide complete sprinkler coverage for the facility. 3.1-19(b)		Ops Director or his designee will audit the closets weekly times 4 then monthly times 6 to ensure the sprinkler heads in the closets remain unobstructed. Ransom audits will continue thereafter to ensure substantial compliance continues. The Fire Protection service provider will check the operation of the sprinkler heads quarterly during the routine fire inspection to ensure they are fully operable. How the corrective action will be monitored to ensure the deficient practice will not recur: The closet audits will be presented to the monthly Quality Assurance Committee times 6 months for further recommendations. The Quarterly sprinkler inspection reports will also be reviewed monthly as part of the Quality Assurance/Safety Committee meeting for recommendations on an on going basis.		

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K0061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on record review and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV) serving the original portion of the facility. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect 49 residents on 100 wing as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on review of of fire and safety reports on 06/08/12 at 2:15 p.m. with the Maintenance Supervisor, a tamper switch was not present on the Post Indicator Valve (PIV) which would report a trouble signal to the fire alarm control panel. Based on interview on 06/08/12 at 2:17 p.m. with the Maintenance Supervisor, it was acknowledged the facility did not</p>	K0061	<p>What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice: A tamper switch will be installed on the Post Indicator Valve (PIV) to electronically report a trouble signal to the fire alarm control panel in the event the PIV malfunctions or the water to the sprinkler system is shut off. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. The tamper switch installation was initiated immediately and will be completed at the earliest convenience. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: The Plant Ops Director will manually activate the tamper switch to ensure it reports an electronic trouble signal to the fire panel on a weekly basis times 4, then monthly times 6 months. The fire system provider will check the system quarterly thereafter during the routine fire inspection. How the corrective action will be monitored to ensure</p>	07/13/2012			

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	have a tamper switch for the PIV serving the original portion of the building. 3.1-19(b)		the deficient practice will not recur: An audit will be developed to document the checks of the tamper switch. The audits will be presented to the monthly Quality Assurance/Safety Committee meetings for 6 months for further recommendations. The quarterly inspection reports from the fire system provider will be reviewed quarterly to ensure continued compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2012
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NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	facility has a capacity of 74 and had a census of 62 at the time of this survey.			