

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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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: 02/17/15</p> <p>Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist & Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Masonic Home 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 three story facility with a basement was determined to be of Type I (332) construction and was fully sprinklered except for the dumbwaiter shaft. The facility has a fire alarm system with smoke detection in the corridors and in</p>	K010000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the "Facility") that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 Programs) To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of stature only</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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K010029 SS=D	<p>all areas open to the corridor. The facility has battery operated smoke detectors installed in TCU resident sleeping rooms on the second floor and has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The certified portion of the facility has a capacity of 173 and had a census of 122 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 for the dumbwaiter shaft.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/24/15.</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 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</p>			

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	<p>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 2 of 16 hazardous areas in the basement such as combustible storage rooms greater than 50 square feet in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. LSC 8.2.3.2.3.2 states where a 20-minute fire protection rated door is required in existing buildings, an existing 1 3/4 inch solid, bonded wood core door, or an existing steel clad wood door, or an existing solid core steel door with positive latch and closer shall be permitted. LSC 8.2.3.2.1(a) states fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition. NFPA 80, Section 2-4.1.1 states where there is an astragal that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other. This deficient practice could affect 5 staff and visitors in the basement.</p>	K010029	<p>K-029 Actions taken: A licensed contractor has installed automatic door closure, coordinators and self-latching devices on the double doors set in the central supply room in the basement of the Indiana Masonic Home Medical Center. The single entrance door to the central supply had an automatic door closure and self-latching device installed. Coordinators have been purchased and installed and self-latching devices on D wing basement doors set in the laundry and housekeeping storage area. The central supply clerk has been educated with a one on one in-service on the safety hazards of the door be propped open. He has been further instructed to never do so again. Other areas identified: All other hazardous areas have been inspected to ensure compliance and that said areas meet all standards. Measures taken to prevent reoccurrence: Ongoing visual checks/audits will be conducted during daily and weekly rounds by Administrator or his designee. Monitored: The result of the audits will be reviewed at the monthly QAPI meeting by the interdisciplinary team. Completion date: 3-6-2015</p>	03/06/2015	

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	<p>Findings include:</p> <p>Based on observations with the Director of Facility during a tour of the facility from 12:10 p.m. to 1:35 p.m. on 02/17/15, the following was noted for two combustible storage rooms greater than 50 square feet in size in the basement:</p> <p>a. the corridor door to one of two entrances to the Central Supply Room was propped in the fully open position with a barbell. The second entrance to the Central Supply Room at the end of the basement corridor was a double door set and each door was not equipped with self closing devices. In addition, the double door set swung in the same direction and was equipped with an astragal but was not equipped with a coordinator to ensure the door which must close last always closes last.</p> <p>b. the D Wing double door set to Housekeeping and Laundry Storage Room swung in the same direction and was equipped with an astragal but was not equipped with a coordinator to ensure the door which must close last always closes last.</p> <p>Based on interview at the time of the observations, the Director of Facility stated each of the aforementioned hazardous area rooms was being utilized as a storage room and acknowledged the</p>				

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K010050 SS=C	<p>aforementioned doors were either propped open or not equipped with self closing devices and coordinators to ensure each door self closes and the door which must close last always closes last.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" and "Evaluation of Fire Drill" documentation with the Director of Facility during record review from 9:50 a.m. to 12:10 p.m. on 02/17/15, third shift fire drills conducted on 03/14/14, 09/24/14 and</p>	K010050	<p>K-50 Actions taken: A fire drill was conducted on the third shift at an unexpected time and with varying conditions. Others residents and staff identified: The fire drills for all other shifts were reviewed and found to be conducted at unexpected times and varying conditions. The standard was met. Prevent reoccurrence: The facility director has created an annual schedule of fire drills, to ensure that all fire drills will be conducted on all shifts at unexpected times and varying conditions. Monitored: The Administrator will review the fire drill calendar on a monthly basis to ensure compliance. Completion – 3/19/2015</p>	03/19/2015

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K010056 SS=E	<p>12/04/14 were conducted at, respectively, 5:48 a.m., 5:20 a.m. and 5:25 a.m. Based on interview at the time of record review, the Director of Facility acknowledged third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1 of 1 service chutes was sprinklered. NFPA 13, 5-13.5 requires building service chutes shall be protected internally by automatic sprinklers. A sprinkler shall be provided above the top service opening of the chute, above the lowest service opening, and above service openings at alternate levels in buildings over two stories in</p>	K010056	<p>K-056</p> <p>Actions Taken:</p> <p>The six openings to the dumbwaiter on all three floors will be sealed with two layers of type x gypsum board, and caulked and sealed with fire proof caulking and spackled and painted to provide a two hour barrier to the shaft.</p> <p>Other identified:</p>	03/19/2015			

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K010062 SS=E	<p>height. The room or area into which the chute discharges shall also be protected by automatic sprinklers. This deficient practice affects 39 residents who reside on the third floor and 46 residents who reside on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 9:20 a.m. to 1:35 p.m. on 02/17/15, the third floor dumbwaiter shaft and the first floor dumbwaiter shaft lacked sprinkler coverage. This was verified by the Maintenance Supervisor at the time of observation and acknowledged by the Director of Facility at the exit conference on 02/17/15 at 1:50 p.m.</p> <p>3.1-19(b)</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</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 300 sprinklers covered in corrosion was replaced. LSC 9.7.5 requires all automatic sprinkler systems shall be</p>	K010062	<p>All other elevator and like kind shafts have been identified and found to be sprinkled in accordance with State regulation.</p> <p>All other elevator shafts are inspected by an outside contractor in accordance with State regulation.</p> <p>All elevator shafts are inspected on a monthly basis by outside contractor per our preventive maintenance contract.</p> <p>Completion: 3/19/2015</p>	03/06/2015			

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K010130 SS=C	<p>inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 27 residents who reside on the 1E Hall near the 1E Hall soiled linen room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor at 12:45 p.m. on 02/17/15, the 1E Hall soiled linen room sprinkler was completely covered in green corrosion. This was verified by the Maintenance Supervisor at the time of observation and acknowledged by the Director of Facility at the exit conference on 02/17/15 at 1:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 12 of 143 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features</p>	K010130	<p>supervisor and Facility Director to ensure compliance and that the regulatory requirement is being met. A routine inspection will be completed on a monthly basis by the Administrator, Maintenance Supervisor or his designee. The monthly inspection will be reviewed at the monthly QAPI meeting by the interdisciplinary team. Date of Completion: 3/6/2015</p> <p>K-130 Actions Taken: We are performing weekly testing and cleaning on all battery operated smoke detectors on TCU A cleaning schedule has been added to the testing form. Others identified: All other smoke</p>	03/06/2015			

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	<p>obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect twelve residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Medical Center Battery Operated Smoke Detector" and "Task Information" documentation with the Director of Facility during record review from 9:50 a.m. to 12:10 p.m. on 02/17/15, documentation of resident sleeping room battery operated smoke detector cleaning was not available for the most recent twelve month period. Review of Family Gard battery operated smoke detector "User's Manual" documentation stated to "clean the smoke alarm at least once a month". Based on interview at the time of record review, the Director of Facility stated Family Gard battery operated smoke detectors are installed in twelve resident sleeping rooms in the TCU on the second floor and acknowledged documentation of battery operated smoke detector cleaning for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p>		<p>detectors have been inspected and found to be direct wired. All direct wired smoke detectors are cleaned and tested by an outside contractor. Prevent reoccurrence: We are keeping weekly testing and cleaning schedules/audits. Monitored: Audits will be reviewed at monthly QAPI committee meeting. Completion: 3/6/2015</p>		