

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2014
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NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
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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: 03/10/14</p> <p>Facility Number: 000036 Provider Number: 155093 AIM Number: 100269640</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Gibson General Hospital-SNF 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 facility was located on the fifth floor of a five story building with a basement which was determined to be of Type I (443) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors</p>	K010000	The SNF requests that the following plan of correction be considered its credible allegation of compliance. The SNF respectfully requests that a post-certification desk review, rather than a post-certification onsite visit, occur to verify compliance.	

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>in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 45 and had a census of 39 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/13/14.</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 39 of 39 residents to accurately address all life safety systems such as the transmission of the fire alarm to the monitoring company/fire department, the evacuation of the smoke</p>	K010048	No residents were affected. It was determined that all residents have the potential to be affected. The following corrective action will be taken: The Facility Services Director (FSD) and SNF Administrator will work cooperatively to update the Emergency Reference's fire section to include: transmission of	04/09/2014	

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	<p>compartment, and staff response to battery operated or single station smoke detectors in resident sleeping rooms, plus a system 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 a review of the Procedures in the Event of a Fire in the Emergency Reference on 03/10/14 at 1:30 p.m. with the Facilities Manager present, the Procedures in the Event of a Fire did not address the transmission of the fire alarm to the monitoring company/fire department, evacuation of the smoke compartment, and staff response to battery operated or single station smoke</p>		<p>the fire alarm to the monitoring company or fire department; evacuation of the smoke compartment; and staff response to battery operated smoke detectors in resident rooms. This update will be completed by 4-4-14. This update will be incorporated into the Emergency Reference by 4-5-14. The following change will take place to assure this does not recur: Training of SNF staff by the SNF Administrator or the FSD or their designees will begin 4-5-14 and will be completed by 4-9-14. Training will include the update to the Emergency Reference's fire section. The Director of Nursing (DON) will add this training component to new SNF hire orientation by 4-9-14. The following monitoring will occur: The DON will report to SNF Performance Improvement Committee (SNF PIC) for at least one year that new hires are being oriented to the Emergency Reference and that all employees are being trained within 30 days of any update. SNF PIC will monitor for compliance and make recommendations as necessary.</p>				

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K010062 SS=C	<p>detectors in resident sleeping rooms. Based on interview at the time of record review, the Facilities Manager acknowledged the Procedure in the Event of a Fire did not include the previously mentioned items.</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 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 03/10/14 between 9:00 a.m. and 10:15 a.m. and again between 1:45 p.m. and 2:15 p.m. during a tour of the facility with the</p>	K010062	No residents were affected. It was determined that all residents have the potential to be affected. The following corrective action will be taken: The Facility Services Director (FSD) will complete or assign an inventory of all sprinkler heads in use on SNF. Inventory results will be used to assure that there are at least two replacement sprinkler heads available for each type of sprinkler head in use. Sprinkler heads will be ordered as needed by Facility Services to complete this task. The following change will take place to assure this does not recur: The FSD will assign the responsibility of a monthly inventory of replacement sprinkler heads that includes verification that there are at least two replacement sprinkler	04/04/2014			

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K010130 SS=C	<p>Facilities Manager, the spare sprinkler head cabinet in the facility had six spare sprinkler heads, however, there were only overhead type sprinkler heads available. There were no pendent type quick response sprinkler heads, pendent type standard response sprinkler heads, or sidewall type sprinkler heads available. These types of sprinkler heads were observed throughout the facility located on the fifth floor. This was acknowledged by the Facilities Manager at the time of observations, furthermore, the Facilities Manager indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to document the maintenance of 27 of 27 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all residents, staff, and visitors in the facility.</p>	K010130	<p>heads on hand for each type used in SNF. The FSD will also implement a process for sprinkler head ordering that assures an ongoing inventory of two or more replacement sprinkler heads for each type in use in SNF (there are three types in use). These two steps will be completed by 4-4-14. The following monitoring will occur to assure compliance: The FSD or his designee will report to SNF PIC for at least one year regarding the inventory of and ordering of replacement sprinkler heads for SNF. SNF PIC will monitor for compliance and make recommendations as necessary.</p> <p>No residents were affected. It was determined that all residents have the potential to be affected. The following corrective action will be taken: The Facility Services Director (FSD) or his designee will be responsible to assure that all smoke detector batteries are replaced between 3-25 and 3-28-14. The person replacing the batteries will be responsible to do so in a way that replacement date is easily verified by looking at the outside of the detector. In addition, a roster will</p>	04/09/2014			

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	<p>Findings include:</p> <p>Based on observation on 03/10/14 between 9:00 a.m. and 10:15 a.m. during a tour of the facility with the Facilities Manager, battery operated smoke detectors were observed in all resident rooms. Based on interview during record review on 03/10/14 at 12:30 p.m., the Facilities Manager said the facility utilizes battery operated smoke detectors in all 27 resident sleeping rooms. Furthermore, the Facilities Manager indicated the batteries in the battery operated smoke detectors in all resident sleeping rooms were changed twice a year during the semiannual time change, however, he indicated there was no written documentation to show the batteries were changed during the past twelve months.</p> <p>3.1-19(b)</p>		<p>be implemented that will identify SNF battery operated smoke detectors by location (SNF detector roster). The roster will include most recent battery replacement date. The next replacement date will be scheduled immediately following battery replacement. The following measures will be put in place so that the deficient practice does not recur: The FSD or his designee will implement and maintain a schedule to assure that smoke detector batteries for SNF are replaced at least every six months and as needed. Battery replacement will be done in a way that will make the replacement date easily verified by looking at the outside of the detector. In addition, a roster will be maintained that will identify SNF battery operated smoke detectors by location (SNF detector roster). The roster will include most recent battery replacement date. The next replacement date will be scheduled immediately following battery replacement. Compliance will be the responsibility of the person who is assigned the task by the FSD. The following monitoring will take place: The FSD or his designee will report to SNF PIC for at least one year regarding the replacement frequency of smoke detector batteries on SNF. SNF PIC will monitor for compliance and make</p>		

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of over 30 alcohol based hand rub dispensers were not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect nursing staff plus any number of residents, as well as other staff and visitors near the Nurses' Station, which was open to the corridor.</p> <p>Findings include:</p> <p>Based on observation on 3/10/14 between 9:00 a.m. and 10:15 a.m. during</p>	K010211	<p>recommendations as necessary.</p> <p>No residents were affected. It was determined that all residents have the potential to be affected. The following corrective actions were taken: the alcohol based hand rub dispenser at the Nurse Station was moved on 3-11-14 so that it was not directly over an electrical outlet. This task was completed by Facility Services. All alcohol based hand rub dispensers in corridors on SNF will be reviewed for compliance with the requirement that they are not installed over an ignition source, including electrical outlets. Any that are not in compliance will be moved or removed by 3-28-14. This task will be a responsibility of the Facility Services Director (FSD) or his designee. The following</p>	04/09/2014			

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	a tour of the facility with the Facilities Manager, the alcohol based hand rub dispenser at the Nurse's Station was mounted on the wall directly above an electrical outlet. During an interview at 9:45 a.m., the Facilities Manager acknowledged the alcohol based hand rub dispenser was placed directly over the electrical outlet at the Nurses' Station. 3-1.19(b)		measures will be put in place so that this does not recur: The FSD will require his or his designee's final approval before alcohol based hand rub dispensers are installed in SNF. This expectation will be communicated to applicable Facility Services staff by 4-2-14. The FSD will not give final approval before verifying each dispenser for a corridor in SNF is not being installed over an ignition source, including electrical outlets. The following monitoring will take place: The FSD will report to SNF PIC for at least one year regarding installation of any alcohol based hand rub dispensers in corridors in SNF and will verify placement was not over an ignition source, including electrical outlets. SNF PIC will monitor for compliance and make recommendations as necessary.		