

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/18/2014
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NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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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: 06/18/14</p> <p>Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Monticello Healthcare 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 is located in a a one story building of Type V (000) construction with a partial basement and on the first floor of a two story building determined to be Type V (111) and both are fully sprinklered. The facility was surveyed as two building due to different construction</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Revisit on or after July 18, 2014.	

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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K010021 SS=E	<p>Types. The facility has a fire alarm system with hard wired smoke detection in the basement, in corridors and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 116 residents and had a census of 90 at the time of this survey.</p> <p>All areas accessible to residents are sprinklered. Areas providing facility services were sprinklered excepts a detached shed and building used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/24/14.</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 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p>						

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	<p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 doors serving hazardous areas such as a storage room for combustibles and caustic chemicals was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more resident near the 1 North resident lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 2:30 p.m., the housekeeping supply room corridor door was held wide open by a chain and hook which attached to the wall behind the door while a housekeeper worked in the room. The device would not allow the door to close automatically upon activation of the fire alarm system. The housekeeper left the room and the door remained open until the maintenance director released the hook from the door knob and allowed the door to close. At 3:50 p.m. on 06/18/14, the door was again observed to be held open</p>	K010021	<p><b>K 021 Doors What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b> The chain and hook door opener have been removed from behind the door by 7-18-14, thus preventing the door from being held open.</p> <p><b>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</b> The chain and hook door opener were removed from behind the door by 7-18-14.</p> <p>Residents, staff and visitors in the One North area have the potential to being affected by the alleged deficient practice. Review of all other storage room doors were completed to ensure no other door openers of this type were in use. Modifications made as needed. <b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</b> Door openers will be visualized during monthly Preventative Maintenance rounds by Maintenance</p>	07/18/2014

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K010022 SS=E	<p>with the chain and hook. The maintenance director agreed at the time of observation, the door and would not automatically close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 1. Based on observation and interview, the facility failed to ensure 4 of 4 resident room doors likely to be mistaken for a way of exit were identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects visitors, staff and 4 of 11 residents on the Moving Forward wing.</p> <p>Findings include:</p>	K010022	<p>Director/Designee to ensure only those that automatically close or are connected to the automatic fire system are in use. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> CQI Audits from monthly Preventative Maintenance rounds will be reported to the Safety Committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p><b>K 022 Exits</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>Signage has been added to the four interior resident room doors indicating the door is not an exit by July 18, 2014. 2. An exterior sign has been ordered to be placed next to the concrete slab on the Moving Forward exit ramp to indicate the direction of the path of egress by following the sidewalk. To be installed by July 18, 2014.</p>	07/18/2014	

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	<p>Based on observation with the maintenance director on 06/18/14 at 3:25 p.m., four doors opened to the outside from resident rooms on the east side of the Moving Forward resident wing. The doors opened onto a small concrete slab separating them from the parking lot by 12 feet of grassy lawn. The maintenance director said at the time of observation, the doors were not meant to be a means of exit during an emergency. There was nothing to notify occupants the doors were not a means of exit during an emergency. He agreed the natural reaction for residents would be to exit through these doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 paths in the exit means of egress from the Moving Forward wing was clearly identified. This deficient practice affects visitors, staff and 11 residents on the Moving Forward wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 3:15 p.m., the ramped north exit from the Moving Forward wing lead to a small</p>		<p><b>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</b></p> <p>All residents, staff and visitors on the Moving Forward hallway have the potential to be affected by the alleged deficient practice. A review of all exit doors and exterior exits/sidewalks was made to ensure no other exits were affected.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</b></p> <p>Exit door signage and exit ramp signage will be visualized and monitored via monthly Preventative Maintenance program by Maintenance Director to ensure all appropriate doors have correct signage.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The corrective actions will be monitored monthly via the Preventative Maintenance rounds to ensure all appropriate exit doors and ramps have correct signage. The results of these audits will be</p>	

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K010038 SS=E	<p>concrete landing separated from the parking lot by a 12 foot unlevel expanse of grassy lawn. The maintenance director agreed at the time of observation, the natural reaction during an emergency evacuation would be to follow the direction of the ramp to the nearest parking lot. He said the actual exit route required two ninety degree left turns to follow a concrete sidewalk to the parking lot at the back of the facility. He acknowledged at the time of observation, a directional exit sign would ensure there was no doubt which way the emergency exit led.</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</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 Moving Forward wing exits was not used for the storage of hazardous materials. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires that an</p>	K010038	<p>reviewed by the Safety committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>K 038 Exits</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>The empty plastic gas can was</p>	07/18/2014			

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	<p>exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff, and 11 residents on the Moving Forward wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 4:00 p.m., the west exit from the Moving Forward wing required egress through a short stairway where a plastic gas can was stored. The maintenance director acknowledged at the time of observation, the combustibile liquid should not have been left in the exit way.</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 Moving Forward wing exit doors equipped with magnetic locks, was 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 egress side. Exception No. 1 requires</p>		<p>immediately removed from the exit area. 2. A code to unlock the door has been posted by July 1, 2014 next to the keypad on the Moving Forward north exit door. 3. The handle lock has been removed from the exterior kitchen door and replaced with a non-locking handle, and the deadlock is left in place by July 18, 2014.</p> <p><b>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. A review of all exit areas to ensure a clear path has been completed. Items were removed as needed. Rounds have been completed of all exit doors to ensure appropriate posting of exit codes. All exit doors have been checked to ensure there is only one single action release method on each door.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</b></p> <p>A review of all exit areas to ensure a clear path was completed on July 1, 2014. Rounds have been completed of all exit doors by July 1, 2014 to ensure appropriate posting of exit</p>				

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	<p>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 that staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 11 residents on the Moving Forward wing.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 06/18/14 at 3:20 p.m., the north emergency exit door from the Moving Forward wing was magnetically locked. The maintenance director demonstrated the locks would release by entering a code into the keypad located on the wall adjacent to the door. The code to unlock the door was not posted. The maintenance director said at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 3 kitchen exit doors was provided with door knobs readily operated by a single action under</p>		<p>codes. All exit doors have been checked by July 1, 2014 to ensure there is only one single action release method on each door. Modifications have been made as needed. The Director of Maintenance/ Designee will complete Preventative Maintenance rounds weekly to ensure all exit paths have clear passage that exit codes are posted and single action release mechanisms on doors are in place.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The corrective actions will be monitored weekly x two months and monthly thereafter by the Maintenance Director via Preventative Maintenance schedules. The results of these audits will be reviewed by the Safety/CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p>				

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	<p>all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release such as a knob and independent dead bolt is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 3 staff and any visitors to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with maintenance director on 06/18/14 at 3:45 p.m., the kitchen door providing an emergency exit to the outside was identified by an illuminated exit sign. The door was equipped with both a locking door knob and locking dead bolt. The maintenance director agreed at the time of observation, the arrangement could require two actions to unlatch the door.</p> <p>3.1-19(b)</p>						

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K010062 SS=F	<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>1. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 4:05 p.m., over head pipes in the maintenance shop supplying the sprinkler system were used to support a length of pipe and wiring. The maintenance director agreed at the time of observation, sprinkler system water supply piping should not be used as hangers.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 7 sprinkler</p>	K010062	<p><b>K 062 Automatic Sprinkler Systems</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>The pipe and wiring that was supported by the sprinkler system has been removed to alleviate contact with the sprinkler system by July 1, 2014. 2. The identified sprinkler heads in the storage closet, shower room, behind the dryers, in the corridor outside the laundry, and those with paint on the heads in the laundry have all been removed, cleaned and/or replaced with new by July 18, 2014.</p> <p><b>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</b></p> <p>All residents have the potential to be affected by this alleged deficient practice. A review of all sprinkler heads throughout the facility has</p>	07/18/2014
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	<p>heads in 2 of 8 smoke compartments were free of foreign materials, such as grime and paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the 1 North and C hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 between 12:40 p.m. and 3:00 p.m., one sprinkler head in the narrow storage closet near the shower room, one sprinkler head in the shower room, and one behind the dryers in the laundry were covered with a thick, gray fuzzy grime. A sprinkler head in the corridor outside the laundry had paint on it and three sprinkler heads in the laundry were coated with a white powdery material. The maintenance director agreed at the time of observations, the foreign materials could affect the function of the sprinkler heads.</p> <p>3.1-19(b)</p>		<p>been completed to ensure no other heads are affected by foreign materials by July 18, 2014. Corrections have been completed as indicated. A review of sprinkler system piping was completed by Maintenance Director by July 18, 2014 to ensure no cords, wiring or piping were attached to the sprinkler pipes.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</b></p> <p>A monthly review of all sprinkler heads and piping will be completed by facility maintenance personnel via the Preventative Maintenance plan. In addition, the contracted sprinkler service company (IEI) will complete an inspection during their quarterly review.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The Preventative Maintenance schedules will be reviewed monthly with results forwarded to the Safety/CQI Committee. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p>				

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 8 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more residents in the 1 North smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 12:10 p.m., the mechanical/electrical room housing electrical circuit and elevator electrical panels was cluttered</p>	K010147	<p><b>K 147 Electrical Wiring</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>All stored items were removed from the area surrounding the electrical panels by July 1, 2014. The electrical receptacle box was reattached and secured to the wall in the kitchen by July 1, 2014.</p> <p><b>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken</b></p> <p>All residents have the potential to be affected by this alleged deficient practice. All kitchen outlets have been inspected by Maintenance personnel to ensure they are intact and secured to the wall. All electrical boxes/rooms have been inspected by Maintenance personnel to ensure a clear path of access to the panels.</p> <p><b>What measures will be put into</b></p>	07/18/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/18/2014
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NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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	<p>with the storage of miscellaneous combustible and noncombustible equipment and materials directly in front of, and against, the panels. The maintenance director agreed at the time of observation, the stored items would have to be moved in order to access the panels.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical wiring and equipment in 1 of 1 kitchens was in compliance with NFPA 70, National Electrical Code, NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect 3 staff and any visitor to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/18/14 at 3:40 p.m., a surface mounted, four outlet receptacle box was located 46 inches from the floor in the kitchen. The box hung loosely with the electrical wiring exposed. The maintenance director said at the time of observation, kitchen staff hit the box with carts repeatedly</p>		<p><b>place or what systemic changes you will make to ensure that the alleged deficient practice does not recur</b></p> <p>Review of all kitchen outlets will be completed monthly via the Preventative Maintenance schedule by Director of Maintenance. Any that have been damaged or loosened will be corrected immediately. In-service training for dietary staff will be completed by 7-18-14 by the Maintenance Director/Designee to ensure understanding of proper electrical precautions. All electrical rooms and panels have been checked by Maintenance Director to ensure clear passage to all electrical panel areas.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The CQI/Preventative Maintenance schedule will be reviewed monthly. The results of these CQI audits will be reviewed by the CQI/Safety committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p>	

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NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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	knocking it loose from a screw intended to hold it securely to the wall. He attempted at the time of observation to reattach the box to the wall, but it could not be done immediately.  3.1-19(b)			