

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
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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: 06/26/14</p> <p>Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Diversicare of Providence LLC 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 (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in all</p>	K010000	<p>This plan of correction constitutes Diversicare of Providence's credible allegation of compliance for the cited deficiency. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.</p>	
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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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K010025 SS=E	<p>resident sleeping rooms. The facility has a capacity of 158 and had a census of 128 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</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 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 smoke barrier walls above the smoke barrier</p>	K010025	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	07/26/2014

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K010067 SS=F	<p>doors was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 24 residents who reside on the 400 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/26/14 at 1:30 p.m., the 400 Hall smoke barrier wall above the drop ceiling lacked drywall on each side of the fourteen foot by four foot length of smoke barrier wall. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/26/14 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p>		<p>The smoke barrier wall above the drop ceiling on 400 hall will have drywall placed on each side of the fourteen foot by four foot length of the smoke barrier wall 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All smoke barrier walls will be audited to verify that no wall is lacking drywall on each side 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Maintenance staff will be in-serviced on monitoring of smoke barrier walls Auditing smoke barrier walls will be added to the preventative maintenance duties 4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Maintenance Director/Designee will audit smoke barrier walls monthly for three months and then quarterly for the remainder of the year and findings to be reported to the QA committee</p>				

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	<p>Based on observation, record review and interview; the facility failed to ensure 7 of 7 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/26/14 during a tour of the facility with the maintenance supervisor from 10:05 a.m. to 1:30 p.m., the corridors throughout the facility had seven fusible link fire dampers located in return air ducts. Based on review of the MTS & D Services service order invoice on 06/26/14 at 11:45 a.m., the seven fire dampers were inspected on 3/23/10,</p>	K010067	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The seven fire dampers will be inspected by a qualified provider</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken The seven fire dampers will be inspected by a qualified provider</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Maintenance staff will be in-serviced on the inspection requirement of fire dampers Fire damper inspection will be added to the TELS system as a reminder of the upcoming inspection</p> <p>4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Maintenance Director/Designee will report findings of fire damper inspection to the QA committee They will also notify QA committee when TELS alerts them of next inspection in 4 years</p>	07/26/2014			

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	<p>which is a period exceeding the four year inspection requirement. The lack of a four year fire damper inspection was verified by the maintenance supervisor at the time of observation and and record review and acknowledged by the administrator at the exit conference on 06/26/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>				