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 01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA MASONIC HOME INC	690 S STATE ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K010000	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). Survey Date: 01/09/14 Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430 Surveyors: Mark Bugni, Life Safety Code Specialist Mark Caraher, Life Safety Code Specialist 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. This three story facility with a basement was determined to be of Type I (332) construction and fully sprinkled. The facility has a fire alarm system with	K010000	The submissison 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, this plan of correction shall serve as the credible allegation of compliance with all state and federal requiremeents governing the management of this facilty. It is thus submited as a matter of stature only.We are respectfully requesting the granting of paper compliance due to the low scope and serverity of the survey findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	smoke detection on all levels including in the corridors, in spaces open to the corridors, with hard wired smoke detectors in resident room 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183,184, 185, 186, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344 and battery operated smoke detectors in resident rooms 263, 265, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276. The healthcare portion of the facility has a capacity of 173 and had a census of 123 at the time of this visit. All areas where residents have customary access were sprinkled. The facility had 5 detached buildings providing facility services which were not sprinkled including the new maintenance building, the storage building, the barn, the laundry building,			

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	and the power house. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/27/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010050 SS=F	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 interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports with the maintenance supervisor on	K010050	Administration and Management The facility must maintain a written fire and disaster preparedness. 1. No resident was negatively affected.2. All residents have the potential to be affected. 3. Maintenance shall be in charge of scheduling and monitoring all unannounced fire drills that will consist of a drill quarterly on each shift. It is the policy of the Indiana Masonic Home to conduct quarterly fire drills in each building, on all three shifts to insure that the current	02/07/2014

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	01/09/14 at 9:25 a.m., a fire drill was not documented for the third shift, third quarter of the year 2013. Additionally, based on interview with the maintenance supervisor and human resource director during the review of the Fire Drill Reports, there was no other documentation available for review to verify a third shift fire drill for the third quarter of the year 2013 was conducted. This was verified by the maintenance supervisor and human resource director at the time of record review and acknowledged by the administrator at the exit conference on 01/09/14 at 2:05 p.m. 3.1-19(b) 3.1-51(c)		undated facility policy titled "Indiana Masonic Home Fire and Disaster Manual" which states, "Each shift will have a fire drill four times annually ..." is followed.The current policy was reviewed and is appropriate. As a means to ensure ongoing compliance the Director of Facilities will monthly audit the Fire Drill record. (See Attachment K0050-1). We will put electronic reminders on the computers of the Director of Facilities, the Director of Human Resources, and the Administrator, since some of these persons are in separate buildings, to insure that these key administrative positions will be aware of the quarterly time frame in which to have fire drills completed on the night shift, day shift, and evening shift in all buildings. This tag was already a part of our Annual Survey and was corrected and in place by 1/10/14. We have also put the dates of drills on a calendar shared by department heads to be sure they happen. Fire drills will be scheduled at the beginning of the year for the entire year. The dates of those will only be shared with the Department Heads and Administration. 4. This will be monitored quarterly and reported at the quarterly CQI meeting by: Director of Facilities, Director of Environmental Services, Director of Human Resources, and the Administrator.	

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K010062 SS=F	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 Based on record review, observation, and interview; the facility failed to ensure 5 of 5 sprinkler system gauges were replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents in the facility. Findings include: Based on a review of Quarterly Sprinkler System Inspection Reports on 01/09/14 at 10:00 a.m. with the maintenance supervisor, there was no record the five sprinkler system gauges had been replaced over the past five years. Based on observations, during a tour of the facility from 9:10 a.m. to 2:00 p.m. with the maintenance supervisor and director of plant operations, the basement B Hall sprinkler riser room two gauges, the basement equipment room sprinkler	K010062	1. No resident was negatively affected. 2. All residents have the potential to be affected. 3. A contractor was hired to replace all sprinkler system gauges throughout the buildings. (See attachment K0062-1) 4. A reminder has been put in place to alert the maintenance staff when this needs to be done again in five years.	02/07/2014

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	riser room one gauge, the third floor 3B Hall sprinkler inspectors test valve gauge, and first floor 1D Hall sprinkler inspectors test valve gauge had dates of manufacturer on each gauge of 2007 and 2008. The lack of the five sprinkler system gauges being replaced every five years was verified by the maintenance supervisor and director of plant operations at the time of observations of the sprinkler system risers and inspector test valves and acknowledged by the administrator at the exit conference on 01/09/14 at 2:05 p.m. 3.1-19(b)			

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K010071 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure 1 of 3 rubbish chutes were provided with latching hardware to allow the rubbish chute door to self close and latch into the door frame. This deficient practice could affect 36 residents who reside on the 1D Hall and use the 1D Hall main dining room, located across the corridor from the soiled linen room. Findings include:	K010071	1. No resident was negatively affected. 2. All residents have the potential to be affected. 3. The rubbish chutes were replaced with self closing and latching hardware (See attachment K0071-1). 4. Maintenance staff have been instructed on the company we use to replace those and staff will be doing a monthly audit to make sure latches on all rubbish chutes are in proper working order. (See Attachment K001-2).	02/07/2014

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	Based on observation with the director of plant operations on 01/09/14 at 1:40 p.m., the 1D Hall soiled linen room rubbish chute door failed to close and latch into the door frame, leaving a one inch gap in the closed position. This was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 01/09/14 at 2:05 p.m. 3.1-19(b)			
K010074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure window curtains	K010074	1. No resident was negatively affected. 2. All residents have the potential to be affected. 3. The	02/07/2014

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	in 9 of 85 first floor residents rooms were flame retardant. This deficient practice could affect 18 residents who reside on the first floor 1E Hall and 1D Hall in rooms 104, 114, 148, 149, 152, 159, 163, 164, and 166. Findings include: Based on observations with the director of plant operations during a tour of the facility on 01/09/14 from 9:10 a.m. to 2:00 p.m., the first floor 1E Hall and 1D Hall resident rooms 104, 114, 148, 149, 152, 159, 163, 164, and 166 each had a window curtain which lacked attached documentation they were inherently flame retardant. Based on interview with the laundry supervisor on 01/09/14 at 1:20 p.m., the above listed resident room residents brought their own window curtains from home are are not flame retardant window curtains. The lack of flame retardant window curtains in resident rooms 104, 114, 148, 149, 152, 159, 163, 164, and 166 was verified by the laundry supervisor at the time of interview and acknowledged by the administrator at the exit conference on 01/09/14 at 2:05 p.m. 3.1-19(b)		Curtain/Drapery policy has been changed to include the treating and ongoing monitoring of all window treatments throughout the building (see attachment K0074-3). Laundering and treatment orders (see attachment K0074-1) will be a part of that monitoring and filled out by the housekeeping person who takes the window treatments for laundering to assure they are treated with fire retardant before being hung. A log will be kept with the room numbers of rooms with window treatments and the date they were last treated (see attachment K0074-2). The person(s) treating the window treatments with flame retardant will use the manufacturer's application spray method (see attachment K0074-4).	