

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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K 0000 Bldg. 01	<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: 08/16/16</p> <p>Facility Number: 000315 Provider Number: 155720 AIM Number: 100289030</p> <p>At this Life Safety Code survey, Cathedral Health Care Center 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 two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 65 and had a census of 45 at the time of this survey.</p>	K 0000	<p>By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 15th, 2016 to the Life Safety Code Recertification Survey conducted on August 16th, 2016. The facility also requests consideration for a desk review.</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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K 0046 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a generator building, and a greenhouse.</p> <p>Quality Review completed on 08/23/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>Based on record review, interview, and observation; the facility failed to ensure 14 of 14 battery powered light sets were tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply)</p>	K 0046	<p>K046</p> <p>It is the practice of this facility to regularly test allemergency lighting systems for 30 seconds monthly & 90 minutes annually.</p> <p><i>The correction action taken for those residents found to beaffected by the deficient practice include:</i></p> <p>There were no specific residents identified but every residentcould be affected by this deficiency. A new Preventative Maintenance Log has been created and willbe utilized to ensure compliance. All results of audits will be submitted forQAPI review.</p> <p><i>Other residents that have the potential to be affected havebeen identified by:</i></p> <p>Potentially all residents could be</p>	09/15/2016

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	<p>equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 08/16/16 at 11:15 a.m. with the Maintenance Director present, there was no documentation to show the fourteen battery back up light sets were tested monthly during the past twelve months, plus, there was no documentation to show they were tested for ninety minutes annually during the past twelve months. This was acknowledged by the Maintenance Director at the time of record review. Based on observations between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director, battery powered light sets were observed throughout the facility.</p> <p>3-1.19(b)</p>		<p>affected. No additional areas were identified per review. Please refer to systems implemented to assure compliance with this deficiency.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The Maintenance Department has been in-serviced related to assuring that each battery powered emergency light is tested for 30 seconds monthly, tested 90 minutes annually and that the results of each test must be documented at time of completion.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i></p> <p>Assuring that each test conducted on battery powered emergency lighting will be monitored as a part of the preventative maintenance review, documented monthly x3, quarterly x3 and presented at the quarterly quality assurance performance improvements meetings.</p> <p>The Maintenance Director, or designee will be responsible for assuring all areas are protected appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for</p>		

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K 0047 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was provided for 1 of 3 ways of exit from the second floor. LSC 19.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect up to 21 residents, as well as staff and visitors in second floor west corridor.</p> <p>Findings include: Based on observation on 08/16/16 at 12:20 p.m. during a tour of the facility with the Maintenance Director, there was no illuminated exit sign on the west side</p>	K 0047	<p>compliance recommendations as needed.</p> <p><i>The date the systemic changes will be completed:</i> September 15th, 2016.</p> <p>K047 It is the practice of this facility to ensure that each exit has a continuously illuminated exit sign. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> The facility has installed a new continuously lighted exit sign on the 2nd floor, west of the new smoke barrier doors. <i>Other residents that have the potential to be affected have been identified by:</i> It was noted in the deficiency that up to 21 residents, along with staff and visitors could be affected. <i>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</i> The Maintenance Department has been in-serviced regarding to the need for each exit to have a</p>	09/15/2016

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K 0050 SS=C Bldg. 01	<p>of the smoke barrier doors separating the east and west second floor corridors. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions,</p>		<p>continuously lighted exit sign at all times.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i> Assuring that each exit has a continuously lighted exit sign will be monitored as a part of the preventative maintenance review, the results will be documented monthly x3, quarterly x3 on the PM log and presented at the quarterly quality assurance performance improvements meetings. The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed.</p> <p><i>The date the systemic changes will be completed:</i> September 15th, 2016.</p>		

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	<p>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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 08/16/16 at 10:30 a.m. with the Maintenance Director present, three of four, second shift (evening) fire drills were performed between 2:24 p.m. and 3:30 p.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p>	K 0050	<p>K050</p> <p>It is the practice of this facility to ensure that fire drills are held at unexpected times under varying conditions.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>A new Preventative Maintenance Log has been created and will be utilized to ensure compliance. All results of audits will be submitted for QAPI review.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>It was noted that all residents could be affected by this deficiency. The Maintenance Director, or designee will ensure that all fire drills are varied more to ensure that the standard is met.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i> There will be at least a two (2) hour time difference between fire drills each</p>	09/15/2016			

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K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In		<p>month, on each shift.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i></p> <p>A new Preventative Maintenance Log has been created and will be utilized monthly x3, quarterly x3 ensure compliance. All results of audits will be submitted for QAPI review.</p> <p>The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed.</p> <p><i>The date the systemic changes will be completed:</i> September 15th, 2016.</p>	

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	<p>Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 9 smoke compartments. This deficient practice could affect up to 30 resident, as well as staff and visitors on the second floor.</p> <p>Findings include:</p> <p>Based on observation on 08/16/16 at 11:55 a.m. during a tour of the facility with the Maintenance Director, there was no sprinkler head in the second floor storage closet across from the old elevator. The Maintenance Director acknowledged there was no sprinkler coverage in the storage closet and said the second floor storage closet was added when the new elevator was installed.</p> <p>3.1-19(b)</p>	K 0056	<p>K056</p> <p><i>It is the practice of this facility to provide an automatic sprinkler system that provides complete coverage in smoke compartments.</i></p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>The facility has scheduled for an automatic sprinkler system to be installed inside the second floor closet, across from the elevator and this will be completed before September 15th, 2016.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>It was noted that up to 30 residents, staff and visitors could be affected by this deficiency. The Maintenance Director, or designee will ensure that all smoke compartments have an automatic sprinkler system installed that provides complete coverage for the smoke compartments.</p> <p><i>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</i></p> <p>The facility has had an automatic</p>	09/15/2016			

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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 1 of 1 water heater and 1 of 1 boiler had inspection	K 0130	sprinkler system installed in the closet on the 2nd floor across from the service elevator. <i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i> A new Preventative Maintenance Log has been created and will be utilized monthly x3, quarterly x3 to ensure compliance. All results of audits will be submitted for QAPI review. The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed. <i>The date the systemic changes will be completed:</i> September 15th, 2016. K130 It is the practice of this facility to ensure that both the hot water heater and boiler systems have current inspection	09/15/2016			

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	<p>certificates that were current to ensure they were in safe operating condition. 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 all resident, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the hot water heater and boiler inspection certificates on 08/16/16 between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director, the water heater and boiler inspection certificates had expiration dates of 12/08/15. Based on interview with the Maintenance Director at the time of observations, it was stated there are no current two year inspection certificates for the hot water heater and boiler.</p> <p>3.1-19(b)</p>		<p>certifications and are in safe working order. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> The facility was able to locate the boiler inspection & hot water inspection that occurred on 1/20/2015. The facility will ensure that a copy of this satisfactory inspection report is kept on file in the Maintenance Office for easy access. <i>Other residents that have the potential to be affected have been identified by:</i> All residents, staff and visitors have the potential to be affected by this deficiency. <i>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</i> The Maintenance Department has been in-serviced on the requirement that the facility must have the hot water heater and boiler systems inspection certificates on hand at all times. <i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i> A new Preventative Maintenance Log has been created and will be utilized monthly x3 and quarterly x3 to ensure compliance. All results of audits will be submitted for QAPI review. The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately.</p>		

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K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on record review and interview, the facility failed to provide documentation the generator was load tested during 2 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a</p>	K 0144	<p>K144 It is the practice of this facility to ensure the generator is inspected weekly, exercised under load for 30 minutes each month and that after each 30-minute test that the generator is allowed a 5-minute cool down period.</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice include:</i> A new preventative maintenance log has been created and will be utilized month and quarterly to ensure compliance. All results of audits will be submitted to QAPI review.</p> <p><i>Other residents that have potential to be affected have been identified by:</i> All residents, staff and visitors have</p>	09/15/2016	

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	<p>minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the monthly generator load testing documentation on 08/16/16 at 10:20 a.m. with the Maintenance Director present, there was no documentation available a load test was performed during September and December of 2015. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure there was documentation 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC</p>		<p>the potential to be affected by this deficiency.</p> <p><i>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</i></p> <p>The Maintenance Department has been in-serviced regarding the requirement that all generator load tests must be documented and that each time a generator load test occurs-a 5-minute cool down must occur.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i></p> <p>A new Preventative Maintenance Log has been created and will be utilized monthly x3 quarterly x3 to ensure compliance. All results of audits will be submitted for QAPI review.</p> <p>The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed.</p>		

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	<p>19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's emergency generator monthly load test log on 08/16/16 at 10:10 a.m. with Maintenance Director present, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. "NA" was documented for each cool down time. During an interview at the time of record review, Maintenance Director confirmed the monthly generator log did not include documentation of a cool down time being</p>		<p><i>The date the systemic changes will be completed:</i> September 15th, 2016.</p>				

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K 0154 SS=C Bldg. 01	<p>recorded.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy for the protection of 45 of 45 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice</p>	K 0154	<p>K154</p> <p>It is the practice of this facility to notify the IndianaState Department of Health, local fire department, fire monitoring service andthe facility's insurance carrier anytime that the facility's fire and orsprinkler system is down for more than four (4) hours in any 24-hour period.</p> <p><i>The correction action taken for those residents found to beaffected by the deficient practice include:</i></p> <p>Thefacility's fire watch policy has been updated to reflect the regulation thateach facility must notify the ISDH, local fire department, fire monitoringservice and facility insurance carrier anytime the facility's fire and orsprinkler system are down for more than four (4) hours in a 24-hour period.</p>	09/15/2016

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	<p>could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 08/16/15 at 9:30 a.m. with the Maintenance Director present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the local Fire Department, Indiana State Department of Health and Insurance Company when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the insurance company, and local Fire Department. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>Current contact numbers for each entity have been added to the fire watch policy as well.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>This deficiency could affect all residents, staff and visitors in the facility.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All staff will be in-serviced on the policy change.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i></p> <p>A new Preventative Maintenance Log has been created and will be utilized monthly x3 quarterly x3 to ensure compliance. All results of audits will be submitted for QAPI review.</p> <p>The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately.</p> <p>Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed.</p> <p><i>The date the systemic changes will</i></p>		

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K 0155 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection of 45 of 45 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during</p>	K 0155	<p><i>be completed:</i> September 15th, 2016.</p> <p>K155 It is the practice of this facility to notify the IndianaState Department of Health, local fire department, fire monitoring service andthe facility's insurance carrier anytime that the facility's fire and orsprinkler system is down for more than four (4) hours in any 24-hour period. <i>The correction action taken for those residents found to beaffected by the deficient practice include:</i> Thefacility's fire watch policy has been updated to reflect the regulation thateach facility must notify the ISDH, local fire department, fire monitoringservice and facility insurance carrier anytime the facility's fire and orsprinkler system are down for more than four (4) hours in a 24-hour period. Currentcontact numbers for each entity have been added to the fire watch policy aswell.</p>	09/15/2016

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	<p>a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 08/16/15 at 9:30 a.m. with the Maintenance Director present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the local Fire Department, Indiana State Department of Health and Insurance Company when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the insurance company, and local Fire Department. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>		<p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>This deficiency could affect all residents, staff and visitors in the facility.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All staff will be in-serviced on the policy change and addition of phone numbers.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance performance improvement is:</i></p> <p>A new Preventative Maintenance Log has been created and will be utilized monthly x3 and quarterly x3 to ensure compliance. All results of audits will be submitted for QAPI review.</p> <p>The Maintenance Director, or designee will be responsible for assuring all areas are monitored and maintained appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventative maintenance documentation quarterly for compliance recommendations as needed.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>September 15th, 2016.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2016

FORM APPROVED

OMB NO. 0938-0391

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