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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155802 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>12/10/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>PROVIDENCE HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1 SISTERS OF PROVIDENCE<br>SAINT MARY OF THE WO, IN 47876 |
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| (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 |
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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: 12/10/13</p> <p>Facility Number: 003624<br/>Provider Number: 155802<br/>AIM Number: 200429840</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Providence Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original North/South wing was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility is located in two, one story buildings: the North-South and the East-West, connected by a thirty foot corridor. The buildings were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire</p> | K010000 |  |  |
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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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|   | <p>alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in the resident sleeping rooms. The facility has the capacity for 68 residents and had a census of 53 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the detached generator room which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/16/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |   |   |                      |   |

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| K010025<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 openings through smoke barriers in 1 of 8 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, from a a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling including interstitial spaces. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, be protected so the space between the penetrating item and the smoke barrier shall be filled with an approved material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff, and 10 or more</p> | K010025   | <p>PHC will ensure that no openings of any size will penetrate the smoke barriers that provide the 1/2 hour smoke resistance in all eight (8) smoke compartments. The four (4) inch opening found in one (1) of the smoke barriers will be repaired with fire resistant drywall and the three (3) conduits will be sealed with smoke and high heat latex that meets the astm specification. Any future work requiring IT to run wire or cable, upon completion, will notify the General Manager (GM). The GM will issue a work order to facilities management for the repair of the smoke barrier with the smoke and fire resistant material. Upon completion the GM will inspect the repair to ensure it meets the 1/2 hour smoke resistant code. All smoke compartments and barrier walls will be inspected by the GM or his designee as part of the monthly preventative maintenance inspection. This</p> | 12/27/2013   |  |   |  |

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|   | <p>residents in the south wing.</p> <p>Findings include:</p> <p>Based on observation with the general manager of operations on 12/10/13 between 11:45 a.m. and 3:00 p.m., a four inch cutout for the passage of three conduits through the wall separating the south electrical room from the adjacent corridor was unsealed. The general manager of operations acknowledged at the time of observation, the gap around the penetrations should have been sealed.</p> <p>3.1-19(b)</p> |   | <p>report will be reviewed by the GM and any violations of this code will be corrected and presented at the monthly Risk Management meeting and reviewed again at the Quarterly Quality Assurance meeting. The Administrator and the houskeeping supervisor will make perodic inspections during the month to prevent this violation in the future.</p> |                      |   |

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| K010130<br>SS=E   | <p>NFPA 101<br/>MISCELLANEOUS<br/>OTHER LSC DEFICIENCY NOT ON 2786<br/>Based on observation, record review, and interview; the facility failed to ensure 1 of 12 boilers had an unexpired certificate of inspection. LSC 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 visitors, staff, and 13 residents on the north/South wing.</p> <p>Findings include:</p> <p>Based on observation on 12/10/13 at 2:25 p.m. with the general manager of operations, boiler # 319907 had a certificate of inspection which expired 10/07/13. The general manager of operations said at the time of observation, he could provide no evidence this vessel had passed an inspection since the previous one done 10/17/11.</p> <p>3.1-19(b)</p> | K010130   | <p>PHC will ensure that all boilers providing steam and hot water to the facility, which includes boiler # 319907 will be inspected prior to expiration and the certificate will be posted as required. On 10-09-13, boiler # 319907 was inspected by an Authorized Inspector from the Travelers Insurance Company. Even though the boiler was inspected on 10-9-13, the certificate was not received until 12-11-13. A scanned copy will be included with the signature page. The General Manager (GM) is responsible for all facilities management including the boiler room. The clerk in facilities management notifies the insurance company 60 days prior to expiration. The GM will monitor the work order program that notifies the insurance company when an inspection is due and when the agent inspects the boiler. If the certificate has not been received within 30 days, he will notify the Administrator. The Administrator will follow up with Travelers to verify the report has been sent to Boiler &amp; Pressure Vessel Section of the IN Division of Fire and Building Safety. However once the inspection has occurred, we lose control over the time in which we receive the certificate. The GM and/or the Administrator will</p> | 12/11/2013           |   |

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|   |  |   | report the status of any boilers awaiting inspections and any certificates still outstanding at the monthly Risk Management meeting. This report will be included in the Quarterly Quality Assurance meeting. |                      |   |

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| K020000   | <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: 12/10/13</p> <p>Facility Number: 003624<br/>Provider Number: 155802<br/>AIM Number: 200429840</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Providence 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) and 410 IAC 16.2. The East/West wing and therapy suite were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The East/West wing is connected by a thirty foot corridor to the north/south building. The facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the</p> | K020000   |   |  |  |   |  |

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|                    | <p>corridors, in spaces open to the corridors, and in resident sleeping rooms. The facility has the capacity for 68 residents and had a census of 53 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |               |   |                      |

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| K020018<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings in 3 of 8 smoke compartments. This deficient practice affects staff, visitors and 10 or more residents in the east/west wing and the facility services smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the general manager of operations on 12/10/13 between 11:45 a.m. and 2:00 p.m., each corridor access door to the east and west shower rooms were equipped with kick down door stops to prevent the doors from closing when engaged. The general manager of operations said at the time of observation, the door stops should have been removed.</p> <p>b. Based on observation with the general manager of operations on 12/10/13 at 1:20 p.m., the unoccupied linen storage room in the service corridor was prevented from closing by a wooden wedge. The general manager of</p> | K020018   | <p>PHC will ensure there are no impediments to closing the 8 doors of the smoking compartments that open into the corridors. The kick down door stops has been removed from the doors one the east and west shower rooms that open in to the hall. The laundry and nursing staff were instructed not to use wooden door wedges to prop open any door leading into the corridor. The wooden wedge found in the unoccupied linen storage room was taken and placed in the trash. An inspection was made of all doors on east, west, north and south for any doors using wooden wedges. Any wedges found in the rooms although no in use was also thrown in the trash. The nonuse of wooden wedges will be apart of the fire and safety training to new hires and yearly training for existing employees. The Administrator, Housekeeping Supervisor and staff will check for the illegal use of these wedges on their daily rounds, if wedges are found, the immediate staff in that area will be counseled and the wedges thrown away. A monthly report will be made to the General</p> | 12/30/2013   |  |   |  |

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|   | <p>operations said at the time of observation, the practice was not approved.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 8 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 6 or more residents in the Physical Therapy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the general manger of plant operations on 12/10/13 between 11:45 a.m. and 3:00 p.m., the physical therapy gym was separated from the exit corridor by a double door set. The door set required one door to be manually latched into the door frame and the second door's dead bolt to be engaged into the first door in order to secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p> |   | <p>Manager by the Housekeeping Supervisor along with other preventative maintenance concerns. The GM will include these findings at the monthly Risk Committee meeting The Administrator will review all reports for the quarter at the Quality Assurance meeting.PHC will ensure that no door in the 8 smoke compartment rooms leading into the corridor cannot automatically latch into the door frame.The double doors going into the therapy gym are now equipped with a latching mechanism that does not automatically lock into the door frame.All sets of double doors were inspected and only the doors going into the gym was deficient.If future renovation or new construction requires doubled doors, the General Manager will ensure the double doors are installed using non automatically latching mechanisms</p> |                      |   |

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| K020022<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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<br/>Based on observation and interview, the facility failed to ensure 2 of 2 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 10 or more residents in the east/west wing.</p> <p>Findings include:</p> <p>Based on observation with the general manager of operations on 12/10/13 between 11:45 a.m. and 3:00 p.m.:</p> <p>a. The south glass paned door to the courtyard from the breezeway could be mistaken for a means of exit to a public way. There was no sign to identify it as "no exit."</p> <p>b. The east activities room had a glass paned door which opened onto the courtyard outside. There was no sign to identify it as "no exit."</p> <p>The general manager of operations said at the time of observations, these doors were not emergency exits but acknowledged</p> | K020022   | <p>PHC will ensure any door that is not an exit or leads to an exit and yet has the appearance of an exit, will have a NO EXIT Sign posted. The door on the east wing activities room had the appearance of an exit door but led into a courtyard. Now, there is a NO EXIT sign placed on the wall by the door on the east activities room door. The south glass paned door in the breezeway appears to lead to an exit but leads to courtyard. Now, there is a NO EXIT sign on the wall beside the south glass paned door leading to the courtyard from the breezeway. After a survey, there are no other doors in the facility that can be mistaken as an exit. The General Manager and Administrator will monitor periodically to make sure these signs stay in place.</p> | 12/26/2013   |  |   |  |

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|   | they might be mistaken for one.<br><br>3.1-19(b)   |   |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br>PROVIDENCE HEALTH CARE CENTER |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1 SISTERS OF PROVIDENCE<br>SAINT MARY OF THE WO, IN 47876 |  |   |  |
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| K020038<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the exit discharge for 3 of 9 emergency exit discharges were arranged to be accessible. LSC 18.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an 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 states, "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 10 or more residents on the east/west wing.</p> <p>Findings include:</p> <p>Based on observation with the general manager of operations on 12/10/13 between 11:46 a.m. and 3:00 p.m., discharge paths for the west exit from the east hall, the west exit from the west hall, and the northwest exit from the west hall were each covered with ice and snow. The general manager of operations agreed the iced exit discharges could interfere with safe exit to the public way in an emergency.</p> | K020038   | <p>PHC shall ensure that means of egress shall be continually free of all obstructions or impediments to full instant use in case of fire or other emergency. The sidewalks on the west exit and from the east hall, the west exit from the west hall and the northwest exit from the west hall have been cleared of ice and snow. The housekeeper supervisor will be responsible for ensuring the sidewalks are continually clear from snow and ice during and after a snow fall. The Administrator and the General Manager will monitor this activity during and after the snow storm. The facility will ensure means of egress through 3 of 3 exit doors equipped with magnetic locks are readily accessible for residents without a clinical diagnosis requiring specialized security measures. All 3 of 3 exits now have posted codes for the egress from the facility. If any new magnetic locking doors are installed, the resident population will have a clinical diagnosis requiring specialized security measures. The Administrator, General Manager and staff will periodically monitor these doors to ensure all codes remain posted and are correct. The facility will ensure all four (4) shower rooms</p> | 12/13/2013   |  |   |  |

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|   | <p>3.1-(19)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 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 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 and 10 or more residents on the east/west wing.</p> <p>Findings include:</p> <p>Based on observation with the general manager of operations on 12/10/13 between 11:45 a.m. and 3:00 p.m., three emergency exit doors on the east/west wing were magnetically locked. Coded keypads adjacent to the locked doors could override the locks and the locks</p> |   | doors knobs can be operated under all lighting conditions and a single action can unlatch the door. The shower doors on east west showers each had a door knob and a deadbolt latch and could not be entered with one motion. The deadbolt latches have been disabled and now only the door knob is used to enter the room. The General Manager and Administrator conducted an inspection of the facility and did not find any other doors where more than one motion was required to open the door. |  |  |   |  |

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|   | <p>released upon activation of the fire alarm system. The codes were not posted. The general manager of operations said at the time of observations, the locks were not needed now as there were no residents considered to be an elopement risk; there were residents with memory impairment but none with 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 2 of 4 shower room exit doors were provided with door knobs readily operated under 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 visitors, staff and 10 or more residents on the east/west wing.</p> <p>Findings include:</p> <p>Based on observation with general</p> |   |   |  |  |   |  |

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|                    | <p>manager of plant operations on 12/10/13 between 11:45 a.m. and 3:00 p.m., doors serving two resident shower rooms on the east/ west wings each had a door knob and dead bolt latch. The general manager of plant operations acknowledged at the time of observations, if the doors were closed and dead bolts engaged while occupied, two operations were required to open the doors.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K020147<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents on the east/west wing.</p> <p>Findings include:</p> <p>Based on observation with the general manager of plant operations on 12/10/13 between 11:45 a.m. and 3:00 p.m.:</p> <p>a. Two power strip extension cords were piggybacked to supply power to a refrigerator in the environmental services office;</p> <p>b. Power strip extension cords were located on the resident bedside walls in resident rooms 127, 132, and 114.</p> <p>The general manager of plant operations acknowledged at the time of observations, the power strips were in use where hard wired electrical outlets should provide the power.</p> | K020147   | <p>PHC, unless specifically permitted will not use flexible cords, power strips or cables as a substitute for fixed wiring in the facility. The two power strip extension cords that were piggybacked to supply power to a refrigerator in the environmental services office have been removed. The power strip extension cords located on the resident bedside walls in resident rooms 127, 132 and 114 have all been removed. At the Resident Council meeting on 12-16-13, The General Manager explained why the power strips had to be removed. Housekeeping staff will monitor daily for any violations of this standard, the Housekeeping Supervisor will include this as part of his preventative maintenance inspection every month. His inspections will include offices, common areas for noncompliance. The Administrator will monitor periodically for violation in resident rooms and offices. Any violations will be included in the GM's report at the monthly Risk Management meeting and contained in the GM's written report at the Quarterly Quality Assurance meeting.</p> | 12/11/2013   |  |   |  |

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|   | 3.1-19(b)  |   |   |                      |   |