

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2014
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NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 LAMMERS PIKE BATESVILLE, IN 47006
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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: 10/15/14</p> <p>Facility Number: 004671 Provider Number: 155742 AIM Number: 200538760</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St Andrews Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare</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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K010143 SS=E	<p>portion of the facility has a capacity of 66 and had a census of 53 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 Dennis Austill, Life Safety Code Specialist on 10/20/14.</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 Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the</p>	K010143	No residents were identified by	11/16/2014			

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	<p>facility failed to ensure 1 of 1 liquid oxygen storage room/transfer rooms was provided with a 45 minute fire rated door. This deficient practice could affect any residents who use the basement therapy room.</p> <p>Findings include:</p> <p>Based on observation on 10/15/14 at 12:15 p.m. with the director of plant operations, the liquid oxygen storage room, located near the center nurses' station, had a door with no fire resistance label. Furthermore, there were three full liquid oxygen containers stored in the room. Based on an interview with the director of plant operations on 10/15/14 at 12:20 p.m., the nursing staff transfers liquid oxygen from large containers into small portable containers for residents in the liquid oxygen room. The lack of a door label on the liquid oxygen room was verified by the director of plant operations at the time of observation and acknowledged at the exit conference on 10/15/14 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>this deficiency statement. On 10/21/14 the door to the oxygen room was labeled with a fire resistance label by the Director of Plant Operations. A ll residents had a potential to be affected. On 10/21/14 the door to the oxygen room was labeled with a fire resistance label. All fire doors were audited on 11/5/14 by the DPO to ensure fire rating posted. Executive Director re-educated the DPO on the regulation 143 regarding proper fire posting on 11-6-14. Auditing for Fire Safety Label will be conducted on all fire doors by the DPO including all new doors being installed. Auditing will be conducted every 2 weeks x 8 weeks and then monthly there after. In addition, compliance will be monitored during peer review process and action plans will be developed for any area of non compliance and will be ongoing until substantial compliance is achieved. <i>All systems will be completed 11/16/14.</i></p>	