

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155290	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/23/2014
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NAME OF PROVIDER OR SUPPLIER  ST ELIZABETH HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 ARMORY RD DELPHI, IN 46923
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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: 07/23/14</p> <p>Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St. Elizabeth Healthcare 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>St. Elizabeth Healthcare Center (the Provider) submits this Plan of Correction (POC) in accordance with specific regulator requirements. The submission of this POC does not indicate an admission by St. Elizabeth Healthcare Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of St. Elizabeth Healthcare Center. This POC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests a desk review of the deficiencies noted.</p>	

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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K010029 SS=E	<p>has a capacity of 64 and had a census of 59 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two garages and a storage shed which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/31/14.</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 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are</p>						

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	<p>separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to hazardous areas such as the kitchen would close and latch securely into its frame and resist the passage of smoke. This deficiency could affect 7 residents observed in the Main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/23/14 at 12:45 p.m. with the Maintenance Supervisor and Administrator, the door which separate the kitchen from Center hall was equipped with spring loaded hinges designed to self close the door and latch it into the frame, but when two attempts were made to test this feature, the door would not close completely and latch into its door frame. Based on interview on 07/23/14 concurrent with the observation with the Maintenance Supervisor and Administrator, it was acknowledged the aforementioned kitchen door did not latch into its frame and would allow the passage of smoke.</p>	K010029	Commercial door closer will be installed on kitchen door at Center (main) hallway by 08/12/2014. Door closer will be tested daily for two weeks to ensure door closes securely and latches into its frame. <b>Monitor weekly as a part of Preventive Maintenance program.</b>	08/22/2014

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K010056 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the Mechanical room were free of obstructions to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 46 residents on 500 hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 07/23/14 at 1:20 p.m. with the Maintenance Supervisor and Administrator, the one sprinkler head in the Mechanical room on 500 hall was blocked by a six inch diameter metal duct</p>	K010056	<p>1) Six-inch diameter metal duct pipe will be relocated to ensure complete sprinkler coverage in Mechanical room in 500 hall by 08/22/2014. Before and after images will be captured and added to internal audit tool.</p> <p>2) The two pendant sprinkler heads located in the ceiling of the Therapy room next to the corridor door will be removed from the automatic sprinkler system not later than 08/22/2014. Before and after images will be captured and added to internal monitoring tool.</p>	08/22/2014

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	<p>pipe which prevented complete sprinkler coverage in the room and subsequently left the area unprotected. Based on interview on 07/23/13 concurrent with the observation it was acknowledge by the Maintenance Supervisor and Administrator, the aforementioned room would have insufficient sprinkler coverage because the six inch diameter duct pipe would block the spray pattern of the sprinkler head.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, Minimum Distance between Sprinklers, states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 7 residents on 300 hall as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observations on 07/23/14 at 1:59 p.m. with the Maintenance Supervisor and Administrator, two pendant sprinkler heads located in the ceiling of the Therapy room next to the corridor door were measured to be forty</p>			

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K010143 SS=E	<p>inches apart. Based on interview on 07/23/14 concurrent with the observation with the Maintenance Supervisor and Administrator, it was acknowledged the aforementioned sprinkler heads observed were less than six feet apart.</p> <p>3.1-19(b)</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 facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 46 residents on 500 hall as well as</p>	K010143	The open air chute in the O2 storage room on the south wing will have electrically-powered mechanical ventilation added not later than 08/22/2014.	08/22/2014	

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	<p>visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 07/23/14 at 1:46 p.m. with the Maintenance Supervisor and Administrator, the oxygen storage room on south wing used to store and transfer oxygen was provided with an open air chute to to outside, but it did not have electrically powered mechanical ventilation. Based on interview on 07/23/14 at 1:50 p.m. it was acknowledged by the the Maintenance Supervisor and Administrator, this room was used to transfer oxygen and they were unaware it was required to have electrically powered mechanical ventilation.</p> <p>3.1-19(b)</p>			
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