

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  08/23/2012
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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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K0000	<p>A Life Safety Code Recertification, State Licensure, and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/23/12</p> <p>Facility Number: 000187 Provider Number: 155290 AIM Number: 100267300</p> <p>Surveyor: Bridget Brown, 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)</p>	K0000	<p>St. Elizabeth Healthcare Center (The Provider) submits this Plan of Correction (POC) in accordance with specific regulatory 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 statute only.</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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms 512 to 523 are equipped with battery powered smoke detectors. The facility has the capacity for 64 and had a census of 57 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, and it was not in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered with the exceptions noted in K-62. Storage sheds for empty oxygen tanks and environmental services paper products were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/29/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory</p>						

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	requirements as evidenced by:			
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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 on 2 of 2 floors 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 that the space between the penetrating item and the smoke barrier shall be filled</p>	K0025	<p>1. All areas cited have been sealed.2. This alleged deficient practice has the potential to affect all residents. Director of Plant Operations (DPO) or designee will round facility in order to identify any penetrations that have not been sealed properly. Any identified areas will be sealed.3. DPO or designee will include auditing facility for unsealed penetrations on his monthly preventative maintenance schedule.4. Trends from audits will be brought to monthly Quality Assurance (QA) meeting for review by QA committee x 3 months or until 100% compliance is achieved.</p>	09/22/2012	

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	<p>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 all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 between 12:45 p.m. and 3:45 p.m.:</p> <ul style="list-style-type: none"> <li>a. A three inch pipe penetrated the service water heater closet ceiling in the mechanical room near the administrator's office with a gap of one half inch and another one inch hole in the ceiling was unsealed;</li> <li>b. Three attic penetrations of the smoke barrier near the administrator's office were unsealed leaving one half to one inch gaps;</li> <li>c. A one inch hole in the dish room ceiling was unsealed;</li> <li>d. A cable penetrating the closet ceiling in the administrator's office left a one half inch gap into the attic above.</li> </ul> <p>The maintenance director</p>			

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	<p>acknowledged at the time of observations, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>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</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill Reports and interview with the maintenance director on 08/23/12 at 3:25 p.m., there was no record of a second shift fire drill for the second quarter during 2012. The maintenance director acknowledged the fire drill report was not there and said he had provided all available fire drill documentation.</p>	K0050	<p>1. The second shift fire drill for second quarter 2012 was not done.2. This alleged deficient practice has the potential to affect all residents.3. All other fire drills for 2012 have been reviewed and are in compliance.4. Director of Plant Operations (DPO) or designee will document monthly fire drills on the appropriate form which indicates which shift each drill is conducted in a visible pattern of compliance. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x 3 months or until 100% compliance is achieved.</p>	09/22/2012			

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	3.1-9(b) 3.1-51(c)			

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K0062 SS=E	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 12 sprinkler heads for 1 of 1 sprinkler systems were free of corrosion and foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the center smoke compartment and under the 300 hall and main entrance canopies.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 between 12:45 p.m. and 3:45 p.m.:</p> <p>a. Six sprinkler heads under the main entrance canopy and four sprinkler heads under the 300 hall exit roof canopy were soiled and turning green. The green patina is usually evidence of corrosion.</p> <p>b. The sprinkler head in the corridor near the social services</p>	K0062	<p>1. All sprinkler heads identified will be cleaned or replaced as necessary. Sprinkler head escutcheons identified have been replaced.2. All residents have the potential to be affected by this alleged deficient practice. Director of Plant Operations (DPO) or designee will round facility to observe condition of all sprinkler heads and placement of escutcheons. Replacement or cleaning will be made as necessary to sprinkler heads and escutcheons.3. DPO will document on monthly Preventative Maintenance schedule that all sprinkler heads have been checked to be free of corrosion and foreign materials and placement of sprinkler head escutcheons is in compliance.4. Trends will be brought to monthly QA (Quality Assurance) meeting for review by QA committee x 3 months or until 100% compliance is achieved.</p>	09/22/2012			

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	<p>office was coated with a powdery gray material;</p> <p>c. The sprinkler head in the biohazard storage room near the nurses' station was coated with a gray fuzzy material. The maintenance director acknowledged at the time of observations, the sprinkler heads should be clean.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 6 smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 between 12:45 p.m. and 3:45 p.m., sprinkler head escutcheons were missing, leaving a gaps of 1/4 to 1/2 inches into the attic above in the the laundry, two in the mechanical room near</p>						

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	<p>the administrator's office, the assistant director of health care services office, in the linen storage room between the 300 and administrative offices halls, the 400 hall janitor's closet, and the social services office. The maintenance director acknowledged at the time of observations, the escutcheons were not in place.</p> <p>3.1-19(b)</p>				

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K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 at 2:00 p.m., the laundry room had two, gas fueled dryers with no fresh air intake. The maintenance director acknowledged at the time of observation, the two gas fueled dryers did not have a fresh air</p>	K0068	<p>1. Fresh air intakes for the two, gas fueled dryers in laundry will be installed.2. All residents have the potential to be affected by this alleged deficient practice. There are no other gas fueled dryers at the facility.3. Director of Plant Operations (DPO) or designee will include checking air intakes on monthly Preventative Maintenance schedule.4. Trends will be brought to monthly Quality Assurance (QA) meeting to be reviewed by QA Committee x 3 months or until 100% compliance is achieved.</p>	09/22/2012

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	intake.  3.1-19(b)			

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K0143 SS=E	<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 transfer sites was separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 at 1:40 p.m., six liquid oxygen supply containers were</p>	K0143	The fire rating was looked at again after the survey visit and found to be a 1 hour door.	09/04/2012	

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	<p>stored in the room identified by the maintenance director as the oxygen transfer room. The door providing access from the exit corridor was rated for 30 minutes. The maintenance director confirmed the door did not provide the minimum 45 minute fire resistance for a door in a one hour rated fire barrier.</p> <p>3.1-19(b)</p>			

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 6 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more resident in the center smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 08/23/12 at 1:35 p.m., a mechanical/electrical room</p>	K0147	<p>1. The electrical room will be free of storage. The storage of equipment and supplies will be removed in order to have access to electrical circuit panels. Junction boxes in the attic will be covered. The electrical receptacle in the administrator's closet ceiling will be covered.2. All residents have potential to be affected by this alleged deficient practice. Director of Plant Operations (DPO) or designee will conduct daily rounds to ensure the electrical room and panels are accessible. DPO will check all junction boxes and receptacles to ensure they are covered. Those not in compliance will be covered.3. DPO will use daily rounding tool to document electrical room is free of storage and panels are accessible. Monthly preventative maintenance schedule will include checking junction boxes and receptacles for proper covering.4. Trends will be brought to Quarterly Assurance (QA) meeting for review by QA Committee x 3 months or until 100% compliance is achieved.</p>	09/22/2012

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	<p>housing emergency generator electrical circuit panels was used for storage of cardboard cartons and activities materials. The storage had to be moved to access the electrical panels. The maintenance acknowledged at the time of observation, the room should be free of storage.</p> <p>b. Based on observation with the maintenance director on 08/23/12 at 1:50 p.m., the electrical room near room 500 was used for the storage of environmental services equipment and supplies which had to be moved to access electrical circuit panels. The maintenance director acknowledged at the time of observation clearance had not been maintained to access the panels.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and</p>				

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  08/23/2012
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	<p>equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on with the maintenance director on 08/23/12 at 1:35 p.m., a junction box in the attic above the sprinkler riser mechanical room was left uncovered. The maintenance director agreed at the time of observation, the box should have been covered.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 6 smoke compartments. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to</p>			

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	<p>contact. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 at 2:45 p.m., an electric receptacle in the administrator's closet ceiling was uncovered. The maintenance director acknowledged at the time of observation, the wiring should have been protected by a face plate.</p> <p>3.1-19(b)</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice</p>	K9999	<p>1. All resident rooms will have smoke detectors installed.2. All residents have the potential to be affected by the alleged deficient practice until smoke detectors are installed.3. Smoke detectors will be added to monthly preventative maintenance schedule for pass/fail test and placement in resident rooms.4. Trends will be brought to monthly Quarterly Assurance (QA) meetings for review by QA Committe x 3 months or until 100% compliance is achieved.</p>	09/22/2012			

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	<p>could affect 47 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/23/12 between 12:45 p.m. and 3:45 p.m., smoke detectors were not installed in resident rooms on the 300 and 400 halls, and 11 resident rooms on the 500 hall. The maintenance director said at the time of observation, he had just been notified and begun to install battery powered smoke detectors.</p> <p>3.1-19(ff)</p>			