

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  11/06/2013
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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 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/06/13</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) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and in spaces open to the corridors. All resident rooms are equipped with battery powered smoke</p>	K010000	<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 statue only. The facility respectfully requests a desk review of the alleged 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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	<p>detectors. The facility has the capacity for 64 and had a census of 63 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Two garages and a storage shed were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 4 smoke compartments had no impediment to closing and would close and latch. 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 Director of Plant Ops on 11/06/13 at 2:55 p.m., the self closing double corridor door set to the medical records office swung in the same direction. One door was equipped with a metal astragal. When this door closed first, the second door hit the astragal and could not close and latch into the door</p>	K010018	<p>1. Self closing double corridor door set to Medical Records was found to not be relied upon to self close and latch every time. The self closing double corridor door set to Medical Records was fastened with door coordinator to ensure self closing feature.2. This alleged deficient practice has the potential to affect all residents.3. All other doors were reviewed to ensure there are means suitable for keeping door closed. Director of Plant Operations (DPO) or designee will review monthly on preventative maintenance schedule the self closing feature of doors.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013

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	<p>frame. The Director of Plant Ops acknowledged at the time of observation, the doors could not be relied upon to self close and latch every time.</p> <p>3.1-19(b)</p>			

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K010025 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 an openings in a ceiling smoke partition in 1 of 4 smoke compartments was sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. 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 with the Director of Plant Ops on 11/06/13 at 3:10 p.m., a three fourths inch annular gap was unsealed around the pendant sprinkler head in resident room 402. The Director of Plant Ops said at the time of observation, he had "missed" sealing this gap.</p> <p>3.1-19(b)</p>	K010025	<p>1. Annular gap around the pendant sprinkler head in resident room 402 was sealed with fire stop and caulk.2. This alleged deficient practice has the potential to affect all residents.3. All pendant sprinkler heads will be reviewed through rounding by Director of Plant Operations (DPO) or designee. Replacement or sealing of any gaps will be made as necessary to sprinkler heads.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013			

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K010029 SS=E	<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 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 provide automatic closers for doors providing access to 1 of 8 hazardous areas such as the kitchen. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the dining room adjoining the kitchen.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Plant Ops on 11/06/13 at 1:55 p.m., two rolling fire doors protected openings between the kitchen and adjoining dining room. No fusible links or other obvious means of automatic closing were evident. A review of the Fire System contractor's</p>	K010029	<p>1. Fire doors between kitchen and adjoining dining room were replaced with automatic closing doors. The door separating the dining room from kitchen was fastened with door closer.2. The alleged deficient practice has the potential to affect all residents.3. All self closing doors will be reviewed monthly on preventative maintenance schedule by Director of Plant Operations (DPO) or designee.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013			

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	<p>08/30/13 inspection of the two fire doors on 11/06/13 at 3:30 p.m., confirmed the fire doors were operated manually and could not self or automatically close upon activation of the fire alarm system. The Director of Plant Ops acknowledged at the time of record review, the doors were not automatically closing.</p> <p>b. Based on observation with the Director of Plant Ops on 11/06/13 at 1:45 p.m., the door separating the dining room from the kitchen had no means to self close. Holes were evident at the top of the door in a location where a self closer was normally installed. The Director of Plant Ops said at the time of observation, a self closer may have been removed.</p> <p>3.1-19(b)</p>				

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K010050 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 affect 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 Director of Plant Ops 11/06/13 at 3:20 p.m., there was no record of a third shift fire drill for the fourth quarter during 2012. The Director of Plant Ops acknowledged at the time of record review, the fire drill was missing.</p> <p>3.1-9(b) 3.1-51(c)</p>	K010050	<p>1. The third shift fire drill for the fourth quarter of 2012 was unable to be located from previous Director of Plant Operations (DPO).2. The alleged deficient practice has the potential to affect all residents.3. All other fire drills have been reviewed and are in compliance. 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.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013			

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to provide the minimum protection between 2 of 2 commercial cooking appliances in the kitchen. NFPA 96, 9-1.2.3 requires deep fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment except where a steel or tempered glass baffle plate is installed at a minimum of eight inches in height between the adjacent appliances. This deficient practice could affect 2 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation of the commercial cooking appliances in the kitchen with the Director of Plant Ops on 11/06/13 at 1:50 p.m., the minimum separation of 16 inches or separation by a steel or tempered glass baffle plate at least eight inches in height was not provided between the range and fryer located side by side. The Director of Plant Ops commented at the time of observation, the fryer had been recently moved.</p> <p>3.1-19(b)</p>	K010069	<p>1. Baffle of appropriate height was installed between the fryer and adjacent cooking equipment in kitchen.2. The alleged deficient practice has the potential to affect all residents.3. Director of Plant Operations (DPO) or designee will be review monthly on preventative maintenance schedule that required separation or baffle are in place between kitchen equipment.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013			

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors, staff and 10 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/06/13 at 2:45 p.m., an electric fireplace was located in the dining room. The maintenance director said at the time of observation, there was a heating element but the fireplace was not in use. During record review on 11/06/13 at 3:20 p.m., the Director of Plant Ops said space heaters were not used. He acknowledged at the time of record review, the electric fireplace could be moved and could be used as a space heater. The facility space heater policy and procedure titled Portable Heaters noted space heaters may not exceed 212 degrees F. There was nothing to evidence the fireplace heating element would not</p>	K010070	<p>1. The electric fireplace located in dining room has a heating element and there was no documentation found to evidence the fireplace heating element would not exceed the 212 F degree limit. The power cord on fireplace was completely removed which renders the heating element inoperable.2. The alleged deficient practice has the potential to affect all residents.3. Director of Plant Operations (DPO) or designee will round to ensure that no space heaters or machines with heating element are in use.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013	

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	exceed the 212 F degree limit.  3.1-19(b)			

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K010073 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure decorations of a highly flammable character were not used in 1 of 2 chapel areas. This deficient practice could affect visitors, staff, and 10 or more residents in the chapel.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/06/13 at 1:30 p.m., three candles with blackened wicks were stored in the chapel sacristy. In addition, a handful of burnt wooden matches lay in an open container beside the candles. A box of wooden matches was kept there as well. The Director of Plant Ops said at the time of observation, the candles were used for religious purposes.</p> <p>3.1-19(b)</p>	K010073	<p>1. Candles have been in use in the chapel sacristy. Director of Environmental Services had conversation with priest and he agreed to no longer use open flame. The candle in the chapel sacristy was replaced with a battery operated substitute.2. The alleged deficient practice has the potential to affect all residents.3. Director of Plant Operations (DPO) or designee will round to ensure no open flames present in chapel and throughout facility.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013	

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K010147 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 a wet location in 1 of 4 smoke compartments was provided with ground-fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect visitors, and 1 or more staff in the medicine room.</p> <p>Findings include:</p> <p>Based on observation with the Director of plant Ops on 11/06/13 at 3:00 p.m., the electrical outlet in the medicine room was located 12 inches from the sink. The outlet was not provided with GFCI protection to prevent electric shock. The</p>	K010147	<p>1. Electrical outlet in the medicine room was replaced with GFCI protection. Power strip extension removed from DHS office. Director of Plant Operations (DPO) removed power strip extension from room 502.2. The alleged deficient practice has the potential to affect all residents.3. Director of Plant Operations (DPO) or designee will round to ensure flexible cords are not used as substitute for fixed wiring.4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x three months or until 100% compliance is achieved.</p>	12/06/2013			

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  11/06/2013
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	<p>Director of Plant Ops said at the time of observation, there was no circuit breaker GFCI for the outlet and the outlet should have had GFCI protection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 4 smoke compartments. NFPA 70 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 10 or more residents, staff, and visitors in the center and west smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 11/06/13 between 1:15 p.m. and 2:00 p.m., a power strip extension cord was used to supply power for a refrigerator and microwave in the DHS office. An oxygen concentrator, suction machine, feeding tube pump and medical grade air mattress were plugged into a surge protected power strip located under the resident bed in room 502. The Director of Plant Ops said at the time of observations, he was unaware the cords</p>				

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	were in use.  3.1-19(b)			