

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN 47710
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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 Dates: 11/13/12</p> <p>Facility Number: 000043 Provider Number: 155104 AIM Number: 100290960</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk thru survey, Heritage 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</p>	K0000		

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>determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 172 and had a census of 149 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage due to lack of sprinkler coverage in a small closet in the Outpatient Room within the Physical Therapy section. The facility was found in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached wood sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/16/12.</p> <p>The facility was found not in</p>			

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	compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=B	<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 14 of 14 sets of double doors to the corridors were equipped with positive latches and latched into their door frames. This deficient practice could affect up to 59 residents, as well as staff and visitors in the 90's hall, Harbor West hall, Horizon's Center hall, and Horizon's West hall.</p> <p>Findings include:</p> <p>Based on observations on 11/13/12 between 11:30 a.m. and 2:30 p.m. during a tour of the facility with the Facility Director, fourteen sets of closet double</p>	K0018	<p>K018 Doors not latching 1. Contractor was secured on November 20 to install self-latching flush bolts. The bolts have been ordered and should arrive by the end of November. The contractor has assured me they will be installed as soon as they arrive. 2. A second inspection has been performed by the maintenance director to insure that no other doors exist in the facility that could create the same or similar issue. 3. The maintenance department will provide ongoing checks to insure the latches operate as intended 4. The maintenance director will be responsible to inspect all areas of the building where construction changes may occur to insure proper latches are installed 5. All latches are expected to be installed by</p>	12/13/2012			

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	doors to the corridors in the 90's hall, Harbor West hall, Horizon's Center hall, and the Horizon's West hall would latch into each other, however, all fourteen sets of double doors would not latch into their respective door frames. This was acknowledged by the Facility Director at the time of each observation. 3.1-19(b)		December 13, 2012		

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K0050 SS=C	<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 held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills on 11/13/12 at 10:00 a.m. with the Facility Director present, three of four second shift (evening) fire drills conducted since November of 2011 were performed between 7:50 p.m. and 8:32 p.m. During an interview at the time of record review, the Facility Director acknowledged the times of the second shift fire drills were not varied.</p>	K0050	<p>050 Fire Drills 1. The policy has been reviewed that fire drills shall be performed at various times for each shift to insure they aren't predictable and that they are completely unexpected by staff. 2. Previous drill times will be checked prior to performing the drill to insure the times are varied. 3. A spreadsheet has been created to log when the fire drill dates and times were performed. Said log will allow the maintenance director to insure times are properly varied. 4. The maintenance director shall be responsible to insure the second shift fire drills will occur at varying times 5. Policy has been reviewed and spreadsheet has been updated and in place on November 21, 2012</p>	12/13/2012			

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	3-1.19(b)			

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K0056 SS=E	<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>Based on observation and interview, the facility failed to provide an automatic sprinkler system to provide complete coverage in 1 of 14 smoke compartments. This deficient practice could affect residents, staff and visitors while in the Physical Therapy section which had at least twenty people in at the time of this survey.</p> <p>Findings include:</p> <p>Based on observation on 11/13/12 at 2:10 p.m. during a tour of the facility with the Facility Director, the closet in the Outpatient Room within the Physical Therapy section was not</p>	K0056	<p>K 056 Sprinkler head missing</p> <p>1.The sprinkler contractor was contacted on November 14 and work began on November 15 to install the sprinkler head in the affected area.</p> <p>2.A second inspection has been performed by the maintenance director to insure all areas of the building have sprinkler coverage.</p> <p>3.The maintenance director will be responsible to inspect all areas of the building where construction occurs to insure that</p>	12/13/2012			

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	<p>provided with a sprinkler head. This was acknowledged by the Facility Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>changes do not affect sprinkler head coverage.</p> <p>4.The maintenance director will be responsible to inspect all areas of the building where construction occurs to insure that changes do not affect sprinkler head coverage. The sprinkler contractor will be called and heads must be installed before walls or room dividers are constructed.</p> <p>5.The sprinkler head was installed and work completed on November 15, 2012</p>		

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K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 3 of 3 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all</p>	K0144	<p>K 144 Generator Load Test Documentation 1. Beginning the month December monthly load test documentation will be changed to the form supplied via the ISDH website. Such forms provide for all the documentation necessary to meet requirements. 2. The facility has a total of 3 generators. All generators will use the same documentation. There is not potential for other residents to be affected. 3. All maintenance personnel will be instructed that the form in the generator log binder is the only acceptable form to be used for documentation 4. The maintenance director shall be responsible to insure the proper forms are used and the generators meet requirements. 5. The new log sheets have been placed in the binders as of November 20, 2012. Documentation to the new log sheets will begin effective December 2012.</p>	12/13/2012

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	<p>residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Generator Log on 11/13/12 at 10:30 a.m. with the Facility Director present, the generator log forms documented the generators were tested monthly under load, however, there was no documentation on the forms that showed the generators were exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since November of 2011. During an interview at the time of record review, the Facility Director confirmed the monthly generator log did not include documentation the generators were exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>			