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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 09/29/2011 |
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| NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC | STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE STREET FRANKLIN, IN46131 |
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| K0000 | <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: 09/29/11</p> <p>Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Masonic Home Inc. 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 three story facility with a basement was determined to be of Type I (332) construction and partially sprinklered. The chapel was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The certified</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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| K0046 SS=E | <p>portion of the facility has a capacity of 172 and had a census of 143 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/05/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 13 battery operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all occupants in the facility including residents, staff and visitors.</p> | K0046 | The staff replaced the entire fixture on the TCU Unit. Fixture tested and working properly.) Continue to maintain monthly audits of all Emergency Lighting. Monitored by: Director of Facilities | 09/29/2011 | |

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| K0048 SS=E | <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 12:50 p.m. to 3:45 p.m. on 09/29/11, the battery operated emergency light identified as TCU #1 located at the second floor nurses' station failed to illuminate when the test button was pressed four times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the battery operated emergency light identified as TCU # 1 failed to illuminate when the test button was pressed.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire | K0048 | The policy in the "Fire and Disaster Manual" has been updated with reference to "Once Fire Suppression System has completed activation then the use of Type K Fire Extinguisher is to be used." Dietary staff will be given inservice on this procedure. Monitored by: Director of Facilities | 10/12/2011 | |

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| | <p>(5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan labeled "Fire and Disaster Manual" for the Indiana Masonic Home with the Director of Facilities from 9:30 a.m. to 12:10 p.m. on 09/29/11, the fire disaster plan did not address the use of the ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Director of Facilities acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p> | | | | |

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| K0052 SS=F | <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of AADCO Alarms "Inspection & Testing Form" dated 07/08/10 during record review with the Director of Facilities from 9:30 a.m. to 12:10 p.m. on 09/29/11, the last documented fire alarm system inspection</p> | K0052 | <p>On 10/4/11 AADCO performed testing and an inspection of the entire Fire Alarm System. All devices tested passed. The Indiana Masonic Home, Inc. plans on implementing a new work order/preventive maintenance software program in May of 2012 called "P.M. Works". This system will provide information to monitor the timing of service and inspections.</p> | 10/04/2011 |

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| | <p>occurred on 07/08/10. Based on interview at the time of observation, the Director of Facilities stated the most recent fire alarm system inspection occurred on 07/08/10 and acknowledged it has been more than one year since the last fire alarm system inspection.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 49 of 337 smoke detectors are maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> | | | | |

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| | <p>(1) Calibrated test method.</p> <p>(2) Manufacturer's calibrated sensitivity test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction.</p> <p>This deficient practice affects 143 of 143 residents, staff and all visitors in the facility.</p> <p>Findings include:</p> | | | |

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| K0064 SS=E | <p>Based on review of AADCO Alarms "Initiating and Supervisory Device Tests and Inspections" documentation dated 07/08/10 during record review with the Director of Facilities from 9:30 a.m. to 12:10 p.m. on 09/29/11, sensitivity testing was not performed for 49 of 337 smoke detectors in the facility. These 49 smoke detectors are identified as duct detectors and each duct detector was functional tested but not sensitivity tested during the facility's 07/08/10 sensitivity testing. Based on interview at the time of observation, the Director of Facilities stated no other sensitivity testing documentation was available for review and acknowledged the 49 duct detectors have not been sensitivity tested in the past two years.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to inspect 3 of 21 portable fire extinguishers for 2 of 12 months. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection</p> | K0064 | On 9/29/11 staff inspected all portable fire extinguishers and found all to be compliant. I) Tags in Radiology Room and 3B hall were brought up to inspection standards. The Indiana Masonic Home, Inc. will implement a new software system that will provide | 09/29/2011 | |

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| | <p>and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure a fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with, and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any resident, staff or visitor in the Radiology Room and in the vicinity of the Soiled Utility Room in the 3B Hall.</p> <p>Findings include:</p> <p>Based on observations with the Director of Facilities and the Maintenance Supervisor during the tour of the facility from 12:50 p.m. to 3:45 p.m. on 09/29/11, the inspection tags affixed to the two portable fire extinguishers in the Radiology Room and the one portable fire extinguisher in the 3B Hall next to the Soiled Utility Room indicated the most recent annual maintenance occurred in June 2011 but no monthly checks for July and August 2011 were documented on the affixed inspection tags. Based on interview at the time of observation, the Maintenance Supervisor stated no other documentation of monthly maintenance</p> | | <p>detail scheduling of fire extinguistor checks and documentation.A placard has been installed on the Fire Extinguisher Cabinet in the kitchen that reads "Fire Suppression shall be activated prior to using the Class K Fire Extinguisher."</p> | | | | |

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| | <p>was available for review and acknowledged no monthly checks in July and August 2011 had been performed for the two portable fire extinguishers in the Radiology Room and the one portable fire extinguisher in the 3B Hall next to the Soiled Utility Room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 portable K class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents, staff or</p> | | | |

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| K0067 SS=F | <p>visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facilities and the Maintenance Supervisor during the tour of the facility from 12:50 p.m. to 3:45 p.m. on 09/29/11, a placard was not conspicuously placed near the K class portable fire extinguisher which states the fire protection system shall be activated prior to using the K class portable fire extinguisher. Based on interview at the time of observation, the Director of Facilities acknowledged no placard was conspicuously placed near the K class portable fire extinguisher stating the fire protection system shall be activated prior to using the K class portable fire extinguisher.</p> <p>3.1-19(b)</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 100 % of fire dampers throughout the facility were</p> | K0067 | On 10/17/11 Facility Director met with Leech & Russell "HVAC Service Contractor", reviewed the | 10/20/2011 | |

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| | <p>inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 143 of 143 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Facilities from 9:30 a.m. to 12:10 p.m. on 09/29/11, fire damper inspection and maintenance documentation records were not available for review. Based on interview at the time of record review, the Director of Facilities stated the facility has fire dampers located in the facility and acknowledged no documentation of fire damper inspection and maintenance records were available for review.</p> <p>3.1-19(b)</p> | | <p>drawings and will begin service on all Fire Dampers on 10/24/11. The new work order system "P.M. Works" will be used to monitor the frequency of this workCompletion Date: 11/15/11 Monitored by: Director of Facilities.</p> | | |

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| K0144 SS=F | <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 3 emergency generators was conducted for 11 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p> | K0144 | <p>Gilpin Electric & Generator Service will install a small load bank device to increase the load to meet the required 30% of the Emergency Power Nameplate Rating. Completion date: 11/15/11 Monitored by: Director of Facilities Gilpin Electric & Generator Service will install three (3) Remote Manual Stops. Completion date: 11/15/11 Monitored by: Director of Facilities A remote annunciator will be installed on all three (3) generators at a location that will be readily observed by staff. Completion date: 11/15/11 Monitored by: Director of Facilities</p> | 11/15/2011 | |

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| | <p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Generator Monthly Load Test" documentation with the Director of Facilities during record review from 9:30 a.m. to 12:10 a.m. on 09/29/11, the 290 kW emergency generator identified as 1-E was run on a monthly basis for at least thirty minutes each month on 10/22/10, 11/30/10, 12/30/10, 01/27/11, 02/28/11, 03/31/11, 05/31/11, 06/29/11, 07/29/11, 08/31/11 but the minimum exhaust gas temperature was not recorded and the percentage of load capacity was recorded as 25 or 29 percent. Based on interview at the time of record review, the Director of Facilities acknowledged the percentage of load capacity recorded for each of the aforementioned months was less than 30 percent of the EPS nameplate rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 3 emergency generators were equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency</p> | | | | |

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| | <p>Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Facilities and the Maintenance Supervisor during the tour of the facility from 12:50 p.m. to 3:45 p.m. on 09/29/11, evidence of a remote shut off device was not found for the 230 kW diesel fired emergency generator identified as the North generator, the 290 kW diesel fired emergency generator identified as 1-E and the 125 kW diesel fired emergency generator identified as 1-D. Based on interview at the time of observation, the</p> | | | | | | |

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| | <p>Director of Facilities stated each emergency generator was installed prior to 2003 and acknowledged there is no remote emergency shut off device for each of the three emergency generators in the facility.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 3 emergency generators were provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> | | | | |

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| | <p>1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations with the Director of Facilities and the Maintenance Supervisor during the tour of the facility from 12:50 p.m. to 3:45 p.m. on 09/29/11, a remote alarm annunciator for each of the three emergency generators identified as the North generator, 1-E and 1-D was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. Based on interview at the time of observation, the Director of Facilities acknowledged each</p> | | | | |

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| | <p>emergency generator was not provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p> <p>3.1-19(b)</p> | | | | |