

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2013
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE RETIREMENT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
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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: 03/05/13</p> <p>Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Providence Retirement Home 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has</p>	K010000		
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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>a capacity of 158 and had a census of 111 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen service metal rolling doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice does not affect any residents since no residents reside on the Center Stage Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/05/13 at 12:30 p.m. during a tour of the Center Stage Hall with maintenance worker # 1, the metal rolling service door between the Center Stage Hall kitchen and Center Stage Hall ballroom was held open with a chain and fusible link, which would not allow the door to close automatically when the fire alarm system is actuated.</p>	K010021	<p>This plan of correction constitutes Providence Retirement Home's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual life safety survey.1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The metal rolling service door between the Center Stage hall kitchen and Center stage hall ballroom has had the manual device removed and replaced with an automatic device that will close automatically when the fire alarm system is actuated.2) How other</p>	04/05/2013			

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	<p>Furthermore, on 03/05/13 at 12:50 p.m. with maintenance worker # 1, the fire alarm system was activated and the Center Stage Hall kitchen metal rolling service door failed to close. This was verified by maintenance worker # 1 at the time of observation and confirmed by the administrator at the exit conference on 03/05/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>		<p>residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The metal rolling service door between the Center stage hall kitchen and the Center stage hall ballroom has had the manual device removed and replaced with an automatic device that will close automatically when the fire alarm system is actuated.3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Maintenance staff will be in-serviced on the need for kitchen service metal rolling doors to be held open by a device which is arranged to automatically close upon activation of the fire alarm system.4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will audit kitchen service metal rolling doors for their ability to be held open by a device that is arranged to automatically close upon activation of the fire alarm system. This audit will be conducted quarterly for one year and findings will reported to the QI committee.</p>	

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K010029 SS=A	<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 ensure the corridor doors to 4 of 4 Center Stage Hall storage rooms used for storage of combustible items and measuring over 50 square feet in size and 2 of 2 Center Stage Hall gas fired equipment rooms were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice does not affect any residents since no residents reside on the Center Stage Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/05/13 during a tour of the Center Stage Hall facility from 12:00 p.m. to 12:20 p.m. with maintenance worker # 1, the door to each of the four Center Stage storage rooms, located behind the stage, which measured between eighty square feet and two</p>	K010029	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Self closing device was added to each of the four Center Stage storage rooms and the two gas fired furnace rooms located by the Center stage Hall.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.Self closing device was added to each of the four Center Stage storage rooms and to the gas fired furnace room located by the Center stage hall.3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Maintenance staff will be in-serviced on the need for any storage area used for storing combustible items and measuring over 50 square feed in size and</p>	04/05/2013			

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	<p>hundred square feet and had combustible storage consisting of twenty two cardboard boxes of clothing and paper, linen storage, and paper files, each lacked a self closing device.</p> <p>Furthermore, the Center Stage Hall gas fired furnace room doors each lacked a self closing device. This was verified by maintenance worker # 1 at the time of observations and confirmed by the administrator at the exit conference on 03/05/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>		<p>any gas fired equipment rooms require a self closing device. Maintenance will add to their monthly preventative maintenance duties to check for these types of rooms on a quarterly basis for a self closing device. 4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Director/Designee will audit storage rooms and gas fired furnace rooms for self closing devices on a monthly basis for three months and then quarterly for the remainder of the year and report finding to the QI committee.</p>		

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 8 of 8 battery backup lights were tested annually for 90 minutes over the past year to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 03/05/13 at 9:45 a.m. with maintenance worker # 1, the Monthly Emergency Light Checklist was reviewed and indicated monthly tests were conducted on eight emergency</p>	K010046	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 8 of the 8 battery back up lights had a 90 minute test completed. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 8 of the 8 battery back up lights will have a 90 minute test completed. 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Maintenance staff will be in-serviced to test the back up lights for 90 minutes on an annual basis. Annual testing of the back up lights for 90 minutes will be added to the preventative maintenance duties checklist. 4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The 90 minute test will be added to the agenda for the QI meeting to review for completion on an annual basis.</p>	04/05/2013			

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	<p>battery backup lights located on each hall in the facility over the past year. Furthermore, the Monthly Emergency Light Checklist lacked an annual ninety minute test of the eight lights listed on the checklist. Based on an interview with maintenance worker #1 on 03/05/13 at 10:10 a.m., the eight battery backup lights were not tested for ninety minutes over the past year. This was confirmed by the administrator at the exit conference on 03/05/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			

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K010062 SS=F	<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>Based on observation and interview, the facility failed to replace 24 of 24 sprinklers located on the facility's outside overhangs which were covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all residents in facility.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 03/05/13 from 9:55 a.m. to 1:15 p.m. with maintenance worker #1, the following outside overhangs had sprinklers covered in green corrosion:</p> <p>a. The six sprinklers on the front exit overhang.</p> <p>b. The two sprinklers on the 900 Hall porch overhang.</p>	K010062	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The following sprinklers have been replaced: (6) on the front exit overhang, (2) on the 900 hall porch overhang, (1) on the 900 hall courtyard, (1) on the 500 hall courtyard, (1) on the 300 hall porch overhang, (1) on the 300 hall exit overhang, (3) on the 200 hall porch overhang, (1) on the therapy porch overhang, (1) on the 600 hall porch overhang, (1) on the 600/800 halls courtyard overhang, (2) on the 800 hall exit overhang, (2) on the chapel porch overhang and (2) sprinklers on the east dining room porch overhang.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All sprinklers outside will be audited for green corrosions and replaced as needed.3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Maintenance staff will be in-serviced that sprinklers need to be replaced if covered in corrosion.An audit of outdoor</p>	04/05/2013			

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	<p>c. The one sprinkler on the 900 Hall courtyard overhang.</p> <p>d. The one sprinkler on the 500 Hall courtyard overhang.</p> <p>e. The one sprinkler on the 300 Hall porch overhang.</p> <p>f. The one sprinkler on the 300 Hall exit overhang.</p> <p>g. The three sprinklers on the 200 Hall porch overhang.</p> <p>h. The one sprinkler on the therapy porch overhang.</p> <p>i. The one sprinkler on the 600 Hall porch overhang.</p> <p>j. The one sprinkler on the 600/800 Halls courtyard overhang.</p> <p>k. The two sprinklers on the 800 Hall exit overhang.</p> <p>l. The two sprinklers on the chapel porch overhang.</p> <p>m. The two sprinklers on the east dining room porch overhang.</p> <p>The outside overhang sprinklers covered with green corrosion were verified by maintenance worker # 1 at the time of observations and confirmed by the administrator at the exit conference on 03/05/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>		<p>sprinklers for corrosion will be conducted on a quarterly basis and replaced as needed.4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Maintenance Director/Designee will audit outdoor sprinklers for corrosion on a quarterly basis for one year and report findings to the QI committee.</p>		