

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155512	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/14/2015
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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710
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K 000  Bldg. 01	<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: 04/14/2015</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>At this Life Safety Code survey, Presence Sacred Heart 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) and 410 IAC 16.2. The original building consisting of the St. Anthony, St. Claire, St. Paul, and the St. Frances neighborhoods as well as the main dining room, chapel and service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K 000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home as a licensed and certified provider recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.	

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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K 025 SS=F Bldg. 01	<p>corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 104 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <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 the penetrations in 6 of 8 fire and smoke barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts,</p>	K 025	<p>Fire Barriers LLC a Hilti Accredited Firestop Contractor to remove existing non-compliant materials and install a firestop joint system that is capable of maintaining the fire resistance of the fire barrier. Maintenance Director responsible Maintenance Director and QA to monitor</p>	05/14/2015

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	<p>cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 4 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Property Manager on 04/14/2015 between 1:13 p.m. to 4:25 p.m., the following was discovered:</p>						

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	<p>A. Electrical room in Memory lane of St Francis 16 " x 8 " gap.</p> <p>B. Electrical room in Oak Street of St Anthony there is fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling.</p> <p>C. Fire wall in main hallway near DON ' s office there was fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling.</p> <p>D. Smoke barrier door entering Pine St had there was fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling.</p> <p>E. Smoke barrier door entering Rehab hall 1/8th inch gap around conduit above ceiling tile.</p> <p>F. Smoke barrier wall in Oak Street at St Anthony there was fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling.</p> <p>G. Fire wall entering Serenity Street there was painted fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling.</p> <p>H. Fire wall entering memory lane there was painted fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay</p>			

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K 040 SS=F Bldg. 01	<p>in ceiling. Based on interview with the Property Manager at the time of observation, he acknowledged the penetrations and fiberglass insulation in each of the discoveries.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit doors on Maple Street in Saint Anthony had a clear width no less than 32 inches wide. LSC 19.2.3.5 requires the clear width of doors in the means of egress from nursing homes shall be no less than 32 inches. This deficient practice could affect any of the 12 residents on Maple Street in Saint Anthony in the event of an emergency evacuation.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 04/14/15 at 2:20 p.m., the exit door in the path of egress on Maple Street in Saint Anthony caught on the ground when opening and failed to open</p>	K 040	Exit door on Maple Street on St. Anthony was grounded on the bottom and a new seal was put on to ensure a clear width no less than 32 inches wide. Maintenance responsible Maintenance and QA to monitor	04/17/2015	

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K 050 SS=E Bldg. 01	<p>fully. Based on interview and the time of observation, the Property Manager acknowledged the door getting stuck on the ground when opening the exit door.</p> <p>3.1-19(b)</p> <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 5 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" on 04/14/2015 at 11:00 a.m. with the Property Manager, the following fire drills were conducted at or near the end of the month: 03/31/15, 05/30/14, 06/30/14, 09/28/14 and 12/30/14.</p>	K 050	<p>Fire Drill schedule with scheduled times and dates was given to Maintenance Director to ensure fire drills are conducted under varying conditions which includes unexpected dates.(see attached fire drill schedule)Maintenance Director is responsibleMaintenance and QA to monitor</p>	04/17/2015

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K 051 SS=D Bldg. 01	<p>Based on interview at the time of record review, the Property Manager acknowledged the requirement of ensuring fire drills are held under varying conditions which includes unexpected dates.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 4 of 6 smoke detectors in the Saint Claire Dining Room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces</p>	K 051	Contractor to relocate the existing 5 smoke detectors in the St Clare dining area to be at least 36 inches away from the closest air diffuser. Maintenance Director responsibleMaintenance Director to monitor	05/06/2015

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K 056 SS=D Bldg. 01	<p>served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 24 residents and staff.</p> <p>Findings include: Based on observation with the Property Manager on 04/14/15 at 1:17 p.m., the Saint Claire Dining Room had smoke detectors located within three feet of a supply air duct. This was acknowledged by the Property Manager at the time of observation.</p> <p>3.1-19(b)</p> <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 ensure complete automatic sprinkler system was provided</p>	K 056	Accordian door was removed from conference room #1 to ensure complete automatic sprinkler coverage of the	05/04/2015

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K 064 SS=E Bldg. 01	<p>for 1 of 1 Conference Room Number Four in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect all staff in the conference rooms.</p> <p>Findings include: Based on observations on 04/14/2015 at 3:04 p.m. with the Property Manager, Conference room number four has a plastic accordion style divider covering a space containing an electrical panel and pneumatics for heating ventilation and cooling. When the accordion style divider is outstretched, there is a lack of sprinkler coverage for the electrical panel and pneumatics. Based on interview at the time of observation, the Property Manager acknowledged the lack of sprinkler coverage if the divider would be extended.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with</p>		conference room.Maintenance Director responsibleMaintenance Director to monitor		

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	<p>9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/14/15 from 12:37 p.m. to 3:39p.m., the Property Manager acknowledged that fourteen fire extinguishers six year applicable maintenance procedures were overdue.</p> <p>A. Serenity Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 12 residents.</p> <p>B. Garden Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 9 residents.</p> <p>C. Vine Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 13 residents.</p> <p>D. Memory Lane 1 of 1 extinguisher last internal inspection date was 2008. This could affect 11 residents.</p> <p>E. Main Street 1 of 1 extinguisher last internal inspection date was 2008. This</p>	K 064	Hydrostatic test will be completed on all 14 fire extinguishers.Maintenance Director responsibleMaintenance Director to monitor	05/14/2015			

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K 069 SS=E Bldg. 01	<p>could affect staff, visitors, and any residents within the area.</p> <p>F. Oak Hall 1 of 1 extinguisher last internal inspection date was 2008. This could affect 14 residents.</p> <p>G. Maple Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 12 residents.</p> <p>H. St Paul lounge 1 of 1 extinguisher last internal inspection date was 2008. This could affect 11 residents.</p> <p>I. Pine Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 15 residents.</p> <p>J. St Paul's kitchen pantry 1 of 1 extinguisher last internal inspection date was 06/2008. This could affect staff only.</p> <p>K. Birch Street 1 of 1 extinguisher last internal inspection date was 2008. This could affect 19 residents.</p> <p>L. Main Kitchen 1 of 2 extinguishers last internal inspection date was 2008. This could affect staff only.</p> <p>M. 1 of 2 Basement extinguishers last internal inspection date was 01/2009. This could affect staff only.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in</p>			

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	<p>accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 4 pantry kitchens. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors using the Saint Anthony kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 04/14/2015 at 1:39 p.m., Cook #1 was observed cleaning up after cooking in the Saint Anthony kitchen under a range hood that lacked an extinguishing system. Based on interview during the time of observation, Cook #1 said she bakes bacon and sausage in the oven. When explained the concerns of fires containing animal and vegetable fats, she acknowledged the oven's range hood was not provided with an</p>	K 069	We have moved production of all animal and vegetable fats to the main kitchen and St. Paul kitchen. Both kitchens are equipped with suppression systems. Dietary Manager responsible Dietary Manager to monitor	04/15/2015			

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K 075 SS=E Bldg. 01	<p>extinguishing system. During interview with Dietitian #1 she confirmed that bacon and sausage is cooked in the oven.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area on 1 of 1 Birch Street. This deficient practice could affect at least 19 residents as well as staff and visitors to Birch Street in Saint Paul.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 04/14/2015 at 2:51 p.m., two 32 gallon containers of biohazardous</p>	K 075	Education provided to staff on proper storage of biohazard recepticle. Biohazard recepticle to be located in a locked room specified for trash and biohazard trash. Regular linen barrels will be kept to a minimum in each hall way to ensure that they do not exceed the 32 gallon per 64 square foot rule. Nurse responsible QA to monitor	05/04/2015

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K 144 SS=F Bldg. 01	<p>soiled linen and trash were stored in the corridor next to each other. Based on an interview at the time of observation, Licensed Practical Nurse #1 confirmed the containers were stored next to each other in the corridor and used for biohazardous linen and trash.</p> <p>3.1-19(b)</p> <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. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p>	K 144	Contractor to remove existing broken ONAM transfer switch cabinet handle and replace with a new one from the manufacturer. Replacement handle will be lockable to prevent access to anyone except authorized personell.Maintenance Director responsibleMaintenance Director to monitor	05/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155512	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/14/2015
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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710
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K 147 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on an observation with the Property Manager on 04/14/2015 at 4:08 p.m., the generator annunciator panel is in the maintenance office which is not manned constantly. Based on an interview with Maintenance at the time of observation, the Property Manager acknowledged that the maintenance office is not a constantly attended area, which would delay response notification if the generator goes into alarm.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall</p>	K 147	<p>1. Multi plug adapter removed from therapy room.2. Secondary nurses station medication room - contractor to install 2 new outlets in the secondary nurses station medication room.St. Paul kitchen - contractor installed a dedicated outlet for the refridgerator.Main kitchen - contractor installed 2 GFI recepticles at drink station.3. Holiday decorations removed to allow at least 3 feet of clearnace</p>	05/12/2015

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	<p>not be used as a substitute for fixed wiring of a structure. This deficient practice could affect facility staff and residents being treated for therapy.</p> <p>Findings include:</p> <p>Based on an observation with the Property Manager on 04/14/2015 at 1:24 p.m., a multiplug adapter was located in the Therapy Room. A fan was plugged into a multiplug adapter. Based on interview at the time of observation, the mutliplug adapter was acknowledged by the Property Manager.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as extension cord power strips were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 staff only.</p> <p>Findings include:</p>		in front of electrical panels.	

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	<p>Based on an observation with the Property Manager on 04/14/15 at 1:50 p.m., an extension cord power strip was plugged in and providing power to a refrigerator in the secondary nurse's station medication room. At the time of observation the Property Manager acknowledged the power strip in the medication room.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure sufficient access and working space for 1 of 1 electrical room was provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment in accordance with NFPA 70, Article 110-26 which requires a minimum of three feet of clearance. This deficient practice could affect any resident, staff and visitors near Hutzell Rehab Suites.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 04/14/2015 at 2:10 p.m., the Mechanical room was being used for storage of holiday decorations and lacked at least three feet of clearance in front of the electrical panels. Based on interview at the time of observation, the Property</p>			

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NAME OF PROVIDER OR SUPPLIER  PRESENCE SACRED HEART HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710		
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K 000  Bldg. 03	<p>Manager acknowledged the room was being used for storage, limiting access to the electrical equipment.</p> <p>3.1-19(b)</p> <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: 04/14/2015</p> <p>Facility Number: 000404 Provider Number: 155512 AIM Number: 100290810</p> <p>At this Life Safety Code survey, Presence Sacred Heart 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) and 410 IAC 16.2. The new section of the building consisting of the H wing was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial</p>	K 000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home as a licensed and certified provider recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.		

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K 050 SS=E Bldg. 03	<p>basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in the resident rooms. The facility has a capacity of 133 and had a census of 104 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 5 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p>	K 050	<p>Fire Drill schedule with scheduled times and dates was given to Maintenance Director to ensure fire drills are conducted under varying conditions which includes unexpected dates.(see attached fire drill schedule)Maintenance Director is responsibleMaintenance and QA to monitor</p>	04/17/2015

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K 144 SS=F Bldg. 03	<p>Based on review of "Fire Drill" on 04/14/2015 at 11:00 a.m. with the Property Manager, the following fire drills were conducted at or near the end of the month: 03/31/15, 05/30/14, 06/30/14, 09/28/14 and 12/30/14.</p> <p>Based on interview at the time of record review, the Property Manager acknowledged the requirement of ensuring fire drills are held under varying conditions which includes unexpected dates.</p> <p>3.1-19(b)</p> <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 observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section</p>	K 144	Contractor to remove existing broken ONAM transfer switch cabinet handle and replace with a new one from the manufacturer. Replacement handle will be lockable to prevent access to anyone except authorized personell.Maintenance Director responsibleMaintenance Director to monitor	05/14/2015

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	<p>4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with the Property Manager on 04/14/2015 at 4:08 p.m., the generator annunciator panel is in the maintenance office which is not manned constantly. Based on an interview with Maintenance at the time of observation, the Property Manager acknowledged that the maintenance office is not a constantly attended area, which would delay response notification if the generator goes into alarm.</p> <p>3-1.19(b)</p>			
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