

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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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: 12/22/14</p> <p>Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Homewood Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</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 hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility</p>	K010000	The facility requests the plan of correction be granted a "desk review" by the Department due to the scope and severity levels of the alleged deficiencies. The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction 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.	

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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K010018 SS=E	<p>has the capacity for 68 and had a census of 49 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/30/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <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 a door protecting</p>	K010018	Corrective Action: The closure device on this door has been repaired and the door closes and	01/21/2015			

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K010044 SS=E	<p>the corridor opening in 1 of 6 smoke compartments automatically latched into the door frame. 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 Environmental Services Supervisor on 12/22/14 at 10:00 a.m., the door protecting the corridor opening to the restorative dining room did not latch when tested twice. The Environmental Services Supervisor acknowledged at the time of observation, the door was not latching into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure fire door sets in 1</p>	K010044	<p>latches properly. Identifying others: The facility maintains all residents residing in the Health Center portion of the campus along with employees would have the potential to be affected. Measures: All fire doors will be checked by Plant Operations personnel or designee on a weekly basis to ensure ongoing compliance. Monitoring: Plant Operations will report out to QA team on a monthly basis to ensure all documented door checks are complete.</p> <p>Corrective Action: The closure device on this door has been repaired and the door closes and</p>	01/21/2015	

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	<p>of 5 smoke compartments were arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff and 10 or more residents in the kitchen and adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 12/22/14 at 10:30 a.m., the fire door set near the kitchen was tested twice and one door in the fire door set failed to latch each time the doors were released to close. The Environmental Services Supervisor acknowledged at the time of observation, there was a problem with the latching mechanism.</p> <p>3.1-19(b)</p>		<p>latches properly. Identifying others: The facility maintains all residents residing in the Health Center portion of the campus along with employees would have the potential to be affected. Measures: All fire doors will be checked by Plant Operations personnel or designee on a weekly basis to ensure ongoing compliance. Monitoring: Plant Operations will report out to QA team on a monthly basis to ensure all documented door checks are complete.</p>		

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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</p> <p>Based on record review and interview, the facility failed to include the evacuation of the smoke compartment, the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 49 of 49 residents in the event of an emergency. LSC 19.7.2.2 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 (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>The plan should include each type of fire extinguisher available and any special requirement for their usage.</p> <p>This deficient practice could affect all</p>	K010048	<p>Corrective Action: The required information has been updated and placed appropriately regarding evacuation route and fire extinguisher type. Identifying Other: The facility maintains that all residents and staff have the potential to be affected. Measures in place: The required information has now been placed in appropriate location and will remain posted. Monitoring: The Plant Operations Director, Dining Service Director and Executive Director share responsibility to monitor through daily rounding that required information is posted at all times.</p>	01/21/2015

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K010051 SS=F	<p>occupants.</p> <p>Findings include:</p> <p>Based on review of the fire policy titled Disaster Preparedness for Fire with the Director of Plant Operations and Administrator on 12/22/14 at 1:10 a.m., the fire safety plan did not identify available fire extinguishers and address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The Director of Plant Operations acknowledged at the time of record review, this element was not addressed in the fire plan.</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</p>						

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	<p>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 maintain 1 of 1 fire alarm systems in accordance with Section 9.6. LSC 9.6.1.4 requires that all facilities maintain the fire alarm system in accordance with NFPA 72. NFPA 72, at 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals shall be distinctly and descriptively annunciated. NFPA 72, at 7-1.1.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm panel with the Director of Plant Operations on 12/22/14 at 11:40 a.m., the fire alarm panel LED showed Trouble-AC power loss. The Director of Plant Operations said at the time of observation he did not know what the trouble meant for the operation of the fire alarm system. The fire alarm system was then activated</p>	K010051	<p>Corrective Action: New Fire alarm panel was installed on January 5th, 2015. Identifying Others: The facility maintains that all residents and staff would have potential to be affected. Measures/Changes: The fire panel was replaced on January 5th, 2015 with a new panel. Monitoring: The fire panel system is monitored, at a minimum, monthly during required fire drills. In addition, the facility arranges for outside vendors to conduct required inspections on all fire equipment as an additional monitoring tool.</p>	01/05/2015			

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K010062 SS=E	<p>and alarmed. However, there was nothing to assure an ongoing AC trouble would not result in the eventual failure of the system if the back up batteries also failed.</p> <p>3.1-19(b)</p> <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 ensure sprinkler heads in 2 of 6 smoke compartments were free of foreign materials, such as paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the dining room and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 12/22/14 between 9:30 a.m. and 11:30 a.m., paint was evident on the sprinklers protecting the women's restroom near the dining room, in the kitchen dry storage</p>	K010062	<p>Corrective Action: Identified sprinkler heads have been cleaned and/or replaced. Identifying Others: The facility identifies residents and staff in the area of these two identified sprinkler heads have potential to be affected. Measures/Changes: Verifying all sprinkler heads are free from debris will be included in the Plant Operations monthly Quality Assurance review. Monitoring: The Director of Plant Operations will review each device monthly and report out to QA committee the results of any findings at the monthly committee meeting.</p>	01/21/2015

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K010067 SS=F	<p>room, the kitchen (one) and three of four sprinklers in the spa. The Environmental Services Supervisor acknowledged at the time of observations, the foreign materials on the sprinklers heads.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 5 of 6 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork 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,</p>	K010067	<p>Corrective Action: Dampers have been inspected by an outside vendor at this time. Identifying Others: The facility maintains that all residents and staff have potential to be affected. Measures/Changes: The Division Plant Operations Support specialist has devised a tracking tool to be utilized to ensure timely inspections and necessary maintenance occurs. Monitoring: The Plant Operations Director, Division Plant Operations Support and Outside vendor all utilize tracking systems to monitor for service due dates.</p>	01/21/2015			

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K010070 SS=E	<p>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 all occupants.</p> <p>Findings include:</p> <p>Based on a review of contractor Fire Safety Inspection and Test Reports with the Director of Plant Operations on 12/22/14 at 1:15 p.m., no record of a fire damper inspection was found. The Director of Plant Operations said at the time of record review, he could not find records of previous inspections and had scheduled an inspection for "next week." He had no confirmation document to support the scheduled inspection and could not remember the contractor who would do the work.</p> <p>3.1-19(b)</p> <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</p>						

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	<p>degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 2 of 2 space heaters were equipped with heating elements which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors, staff and 10 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 12/22/14 between 9:30 a.m. and 10:00 a.m., space heaters were located in the Director of Residential Services and the Administrators office. The Environmental Services Supervisor said at the time of observations, these space heaters had been approved for use by the Fire Marshall. An interview with the maintenance director on 12/22/14 at 12:00 p.m., revealed there was no documentation to evidence the heating elements for the space heaters did not exceed 212 degrees F. The Administrator said at the time of interview on 12/22/14 at 12:15 p.m., he could not find a policy for the use of space heaters in the facility.</p> <p>3.1-19(b)</p>	K010070	<p>Corrective Action: The facility could not find regulation specifics to having space heaters in non-resident areas. However, a policy is instituted to not utilize heaters without evidence that they are equipped with heating elements which do not exceed 212 degrees (F) Identifying Others: The facility contends that residents, staff and visitors have the potential to be affected.Measures/Changes: Institute a policy that heaters will not be utilized without providing evidence that they are equipped with heating elements which do not exceed 212 degrees (F).Monitoring: The Director of Plant Operations, Executive Director or designee will monitor for compliance through daily rounding of facility.</p>	01/21/2015			

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K010073 SS=D	<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 flammable decorations were not used in 1 of 30 resident rooms. This deficient practice could affect visitors, staff and 2 residents in room room 109.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Service Supervisor on 12/22/14 at 11:25 a.m., three wicked candles were located in resident room 109 on the window sill among other holiday decorations. The Environmental Services Supervisor acknowledged at the time of observation, the candles were an inherently flammable decoration.</p> <p>3.1-19(b)</p>	K010073	<p>Corrective Action: The wicks of the candle found in one resident room have been trimmed so that the decoration is no longer flammable. Identifying others: The facility maintains that all residents and staff have the potential to be affected. Measures/Changes: Resident and/or responsible parties will be notified during the move in paperwork process that such flammable items are not allowed in the facility. Monitoring: Director of Plant Operations, Director of Environmental Services, Executive Director, Director of Health Services or designees shall monitor for compliance during daily rounding and routine room housekeeping.</p>	01/21/2015
K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration</p>			

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	<p>areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases in a soiled utility room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. 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 Environmental Services Supervisor on 12/28/14 at 12:10 p.m., one oxygen e-cylinder was stored without support in the soiled utility room near the nurses station. The Environmental Services Supervisor acknowledged at the time of</p>	K010076	<p>Corrective Action: The cylinder was removed and returned to the vendor. Identifying Others: The facility maintains all residents and staff have the potential to be affected. Measures/Chages: All cylinders of nonflammable gases are to be properly stored, chained or supported in a cylinder stand or cart. The facility already utilizes this policy and this one cylinder was left unsecured by an outside vendor. Executive Director or designee will ensure all vendors are aware of safety policy regarding such cylinders. Monitoring: The Executive Director and Director of Health Services or designee will monitor for compliance through daily rounding.</p>	01/21/2015			

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K010130 SS=E	<p>observation, the cylinder could be knocked over and damaged without support.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases in the kitchen was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice</p>	K010130	<p>Corrective Action: The identified cylinder was secured immediately after notification at the time of this survey. Identifying Others: The facility maintains all residents and staff have potential to be affected. Measures: The dietary staff was in-serviced regarding the policy to keep such cylinders secured. Monitoring: The Food Service Director or designee will monitor for continued compliance through daily inspection.</p>	12/22/2014			

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K010147 SS=E	<p>could affect visitors, staff and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 12/22/14 at 10:15 a.m., one carbon dioxide gas cylinder was stored without support in the kitchen adjacent to another, which had been secured with a chain. The Environmental Services Supervisor said at the time of observation, she did not know the cylinder should have also been chained.</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 Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 3 of 6 smoke compartments.</p>	K010147	<p>Corrective Action: The identified flexible cords were removed. Identifying Others: The facility maintains all residents have the potential to be affected. Measures/Changes:</p>	01/21/2015

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	<p>NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, 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, visitors and 10 or more resident in the center, 100, and 200 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 12/22/14 between 9:30 a.m. and 11:50 a.m., power strip extension cords were used to supply power to a soup pot in the dining room and a refrigerator in the Assessment Directors office. Power strip extension cords were also located under the head of the bed in resident room 210; one under the bed and on top of the bed to power light and other equipment in resident room 204. Resident rooms 201, 114, and 109 had power strip extension cords plugged into the bed side walls to supply power to devices. The Environmental Services Supervisor said at the time of observations, there were not enough electrical outlets for equipment.</p> <p>3.1-19(b)</p>		The facility will remove any devices that do not meet regulation or are improperly placed. Monitoring: The Director of Plant Operations, Director of Environmental Services, Executive Director or designee will monitor through daily rounding to ensure only proper devices are used and only in proper wall receptacles.				

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K010155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview the facility failed to provide and implement a complete written policy for procedures to be followed to protect 49 of 49 residents when the fire alarm system was placed out of service for four or more hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p>	K010155	<p>Corrective Action: The facility utilizes a Fire Watch Policy and Procedure that staff ore oriented to upon hire with verifying signature. This policy was in place at the time of the survey, but was not provided to the surveyor at fault of facility.</p> <p>Identifying Others: All residents and staff are identified as having potential to be affected.</p> <p>Measures/Changes: The facility</p>	01/21/2015

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	<p>Findings include:</p> <p>Based on review of the facility's Emergency Fire Watch policy and procedure provided as evidence of procedures followed in the event the fire alarm system was out of service with the administrator and maintenance director on 12/22/14 at 1:30 p.m., the policy and procedure was incomplete. The procedure did not include the requirement for the fire watch designee to have no other duties. Additionally, a fire watch was implemented on 09/29/14 at 9:00 p.m. after the manual pull stations were found to be nonfunctioning at 7:00 p.m that evening. Facility procedures were not followed when staff were assigned to perform the fire watch while performing their usually assigned tasks. Signatures of fire watch designees were compared with staff schedules for 09/29/14 and 09/30/14 to confirm their work status and the Administrator acknowledged the staff assigned were also on regular duty. In addition, the fire watch was done every 30 minutes rather than the required 15 minutes and the 15 minutes designated in the Emergency Watch Policy. The Indiana State Department of Health was not notified. The Administrator and Director of Plant Operations acknowledged at the time of</p>		<p>will continue to utilize the Fire Watch Policy as a training tool and documented confirmation of the training. Additionally, the facility will ensure, going forward, that specific team members are assigned to Fire Watch duties with no other responsibilities as the regulation indicates. Monitoring: The Director of Plant Operations, Executive Director, Director of Health Services are the authorized initiators for Fire Watch and will ensure the procedure is followed as defined in the facility policy.</p>		

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K020000	<p>record review, the fire watch designee element of the fire watch requirement was omitted, and, when implemented the facility policy and requirements were not followed.</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: 12/22/14</p> <p>Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code Recertification survey, Homewood Health Campus was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association</p>	K020000	The facility requests the plan of correction be granted a "desk review" by the Department due to the scope and severity levels of the alleged deficiencies. The submission of this plan of correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all				

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K020048 SS=C	<p>(NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The addition to the 300 hall after March 2003 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This addition to the 300 hall was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 68 and had a census of 49 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include the evacuation of the smoke compartment,</p>	K020048	<p>state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p> <p>Corrective Action: The required information has been updated and placed appropriately</p>	01/21/2015			

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	<p>the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 49 of 49 residents in the event of an emergency. LSC 19.7.2.2 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 (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>The plan should include each type of fire extinguisher available and any special requirement for their usage. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire policy titled Disaster Preparedness for Fire with the Director of Plant Operations and Administrator on 12/22/14 at 1:10 a.m., the fire safety plan did not identify available fire extinguishers and address the K class fire extinguisher located in</p>		<p>regarding evacuation route and fire extinguisher type. Identifying Other: The facility maintains that all residents and staff have the potential to be affected. Measures in place: The required information has now been placed in appropriate location and will remain posted. Monitoring: The Plant Operations Director, Dining Service Director and Executive Director share responsibility to monitor through daily rounding that required information is posted at all times.</p>				

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K020051 SS=F	<p>the kitchen in relationship with the use of the kitchen overhead extinguishing system. The Director of Plant operations acknowledged at the time of record review, this element was not addressed in the fire plan.</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, 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 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, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with Section 9.6. LSC 9.6.1.4 requires that all facilities maintain the fire alarm system in accordance with NFPA 72. NFPA 72,</p>	K020051	<p>Corrective Action: New Fire alarm panel was installed on January 5th, 2015. Identifying Others: The facility maintains that all residents and staff would have potential to be affected. Measures/Changes: The fire panel was replaced on January</p>	01/05/2015	

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K020067 SS=F	<p>at 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals shall be distinctly and descriptively annunciated. NFPA 72, at 7-1.1. states system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm panel with the Director of Plant Operations on 12/22/14 at 11:40 a.m., the fire alarm panel LED showed Trouble-AC power loss. The Director of Plant Operations said at the time of observation he did not know what the trouble meant for the operation of the fire alarm system. The fire alarm system was then activated and alarmed. However, there was nothing to assure an ongoing AC trouble would not result in the eventual failure of the system if the back up batteries also failed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p>		<p>5th, 2015 with a new panel. Monitoring: The fire panel system is monitored, at a minimum, monthly during required fire drills. In addition, the facility arranges for outside vendors to conduct required inspections on all fire equipment as an additional monitoring tool.</p>				

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	<p>Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 5 of 6 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork 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 all occupants.</p> <p>Findings include:</p> <p>Based on a review of contractor Fire Safety Inspection and Test Reports with the Director of Plant Operations on 12/22/14 at 1:15 p.m., no record of a fire damper inspection was found. The Director of Plant Operations said at the time of record review, he could not find records of previous inspections and had scheduled an inspection for "next week."</p>	K020067	<p>Corrective Action: Dampers have been inspected by an outside vendor at this time. Identifying Others: The facility maintains that all residents and staff have potential to be affected. Measures/Changes: The Division Plant Operations Support specialist has devised a tracking tool to be utilized to ensure timely inspections and necessary maintenance occurs. Monitoring: The Plant Operations Director, Division Plant Operations Support and Outside vendor all utilize tracking systems to monitor for service due dates.</p>	01/21/2015	

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K020155 SS=F	<p>He had no confirmation document to support the scheduled inspection and could not remember the contractor who would do the work.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview the facility failed to provide and implement a complete written policy for procedures to be followed to protect 3of 3 residents when the fire alarm system was placed out of service for four or more hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Fire Watch policy and procedure provided as evidence of procedures followed in the event the fire alarm system was out of service with the</p>	K020155	<p>Corrective Action: The facility utilizes a Fire Watch Policy and Procedure that staff ore oriented to upon hire with verifying signature. This policy was in place at the time of the survey, but was not provided to the surveyor at fault of facility.</p> <p>Identifying Others: All residents and staff are identified as having potential to be affected.</p> <p>Measures/Changes: The facility will continue to utilize the Fire Watch Policy as a training tool and documented confirmation of the training. Additionally, the facility will ensure, going forward, that specific team members are assigned to Fire Watch duties with no other responsibilities as the regulation indicates.</p> <p>Monitoring: The Director of Plant Operations, Executive Director,</p>	01/21/2015			

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	<p>administrator and maintenance director on 12/22/14 at 1:30 p.m., the policy and procedure was incomplete. The procedure did not include the requirement for the fire watch designee to have no other duties. Additionally, a fire watch was implemented on 09/29/14 at 9:00 p.m. after the manual pull stations were found to be nonfunctioning at 7:00 p.m that evening. Facility procedures were not followed when staff were assigned to perform the fire watch while performing their usually assigned tasks. Signatures of fire watch designees were compared with staff schedules for 09/29/14 and 09/30/14 to confirm their work status and the Administrator acknowledged the staff assigned were also on regular duty. In addition, the fire watch was done every 30 minutes rather than the required 15 minutes and the 15 minutes designated in the Emergency Watch Policy. The Indiana State Department of Health was not notified. The Administrator and Director of Plant Operations acknowledged at the time of record review, the fire watch designee element of the fire watch requirement was omitted, and, when implemented the facility policy and requirements were not followed.</p> <p>3.1-19(b)</p>		Director of Health Services are the authorized initiators for Fire Watch and will ensure the procedure is followed as defined in the facility policy.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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