

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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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: 01/22/14</p> <p>Facility Number: 011049 Provider Number: 155670 AIM Number: 200258520</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare of Newburgh 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to</p>	K010000	<p>This Plan of Correction is submitted under the State and Federal regulations and statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on the part of the facility. We request this written Plan of Correction serve as our credible allegation of compliance. In addition, we are requesting this Plan of Correction be considered for desk review compliance. Since desk review compliance has been requested, I can fax or mail completed work orders, reports from FESCO and Nixon Power Services once scope of work has been completed, in addition the the exhibits included with this plan of correction to further validate substantial compliance. Should you have any questions, please feel free to contact me at (812) 473-4761. Sincerely, Fairley (Lee) R. Taylor Jr., HFA Administrator.</p>	

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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K010046 SS=C	<p>the corridors, and all resident sleeping rooms. The facility has a capacity of 120 and had a census of 83 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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, observation and interview; the facility failed to ensure the documentation for the testing of 5 of 5 battery powered light sets was complete when testing monthly for 30 seconds. LSC 101, 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. Equipment shall be fully operational for the</p>	K010046	It is the practice of this facility to provide emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9.19.2.9.11. Emergency lighting annual 1 1/2 hour test was completed by plant operations director on 1/22/14 with testing log being completed to show annual testing completed in all 5 locations where emergency lights present for 2014 (Exhibit A). The 30-second monthly test was also completed on	01/30/2014

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	<p>duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires Emergency Power Supply (EPS) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Battery Lights log in the Life Safety Reports book on 01/22/14 at 9:45 a.m. with the Plant Operations Director present, there was no documentation to show the five battery back up light sets in the facility were tested monthly for at least thirty seconds since April of 2013. This was confirmed by Plant Operations Director at the time of record review. Based on observation between 10:45 a.m. and 1:00 p.m. during a tour of the facility with the Plant Operations Director, all battery back up light sets worked properly.</p> <p>3-1.19(b)</p>		<p>1/30/14 and recorded on the testing log.II. All staff, residents and visitors have the potential to be affected. Emergency lighting annual 1 1/2 hour test was completed to show annual testing completed in all 5 locations where emergency lights present for 2014 (Exhibit A). The 30-second monthly test has also been completed 1/30/14 and recorded on the testing log. The Plant Operations Director was terminated on 1/22 /14.III. Inspection reports and monthly testing logs will be reviewed by plant operations director or designee and the administrator or designee monthly for compliance. This will be an ongoing review process.IV. Monthly inspection reports, testing logs will be reviewed in QA meeting monthly x 6 months or until 100% compliance has been achieved.</p>				

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 the documentation for the annual testing of 131 of 131 smoke detectors, plus all pull stations and other devices connected to the fire alarm system was complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's annual fire alarm system inspection testing report in the Life Safety Reports book on 01/22/14 at 8:45 a.m. with the Plant Operations Director present, the annual fire alarm system inspection report dated 09/02/13 did not include complete information for visual and functional testing of smoke detectors and all other devices connected to the fire alarm system. During an interview at the time</p>	K010052	<p>It is the practice of this facility to ensure 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. 9.6.1.4I. A follow-up inspection has been scheduled for all smoke detectors and all other devices connected to the fire alarm system for February 13, 2014. This follow-up inspection report will indicate the correct number of smoke detectors in the facility and will show both visual and functional testing completed for all devices connected to the fire alarm system as required (Exhibit B). The previous vendor report dated 5/14/12 did list 126 smoke detectors but listed 5 duct detectors. The new vendor counted all as smoke detectors on 9/2/13 report giving the 131 count so that's why there was a discrepancy in the count.II. All residents, staff and visitors have the potential to be affected. A</p>	02/21/2014			

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	<p>of record review, the Plant Operations Director acknowledged the fire alarm inspection report dated 09/02/13 did not include complete information for visual and functional testing of all devices.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 5 of 131 smoke detectors had been tested for sensitivity. LSC 9.6.1.4 refers to 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> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity</p>		<p>follow-up inspection has been scheduled for all smoke detectors and all other devices connected to the fire alarm system for February 13, 2014. This follow-up inspection report will indicate the correct number of smoke detectors in the facility and will show both visual and functional testing completed for all devices connected to the fire alarm system as required (Exhibit B). The previous vendor report dated 5/14/12 did list 126 smoke detectors but listed 5 duct detectors. The new vendor counted all as smoke detectors on 9/2/13 report giving the 131 count so that's why there was a discrepancy in the count. III. Monthly inspection reports/logs/preventative maintenance reports to be reviewed monthly by the plant operations director or designee and the administrator or designee for compliance. This review will be on an ongoing basis. The facility has requested desk review compliance and can submit the completed inspection reports via mail or fax to the life safety division upon completion.IV. Monthly inspections reports/logs and preventative maintenance reports will be reviewed in the QA meeting monthly x 6 months or until 100% compliance has been achieved.</p>				

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	<p>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. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p>						

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	<p>Based on review of the smoke detector sensitivity records in the Life Safety Reports book on 01/22/14 at 8:45 a.m. with the Plant Operations Director present, the most recent sensitivity test documentation dated 05/14/12 showed 126 smoke detectors were tested, however, the most recent annual fire alarm system inspection dated 09/02/13 showed there were 131 smoke detectors tested. The facility was not able to produce documentation to show if five additional smoke detectors were added to the facility since the 05/14/12 sensitivity test was performed. Based on interview at the time of record review, the Plant Operations Director acknowledged there was a discrepancy in the number of smoke detectors listed between the sensitivity test date of 05/14/12 and the most recent annual fire alarm system inspection date of 09/02/13.</p> <p>3.1-19(b)</p>			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring takes place, was provided with mechanical ventilation. This deficient practice could affect up to 10 residents, as well as staff and visitors while in the Physical Therapy area where the oxygen storage/transfer room was located.</p> <p>Findings include:</p> <p>Based on observation on 01/22/14 at 11:00 a.m. during a tour of the facility with the Plant Operations Director, the oxygen storage/transfer room had seven large liquid oxygen tanks. There was no mechanical ventilation unit provided in this room. This was acknowledged by</p>	K010143	<p>It is the practice of this facility to ensure transferring of oxygen is:</p> <p>(a) seperated from any portion of the facility wherein patients are housed, examined, or treated by a seperation of a fire barrier of 1-hour fire resistive construction;(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 I. The facility did in fact have mechanical ventilation unit provided and functioning in the oxygen storage and transfer room at the time of the survey. The</p>	01/22/2014			

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	the Plant Operations Director at the time of observation. 3.1-19(b)		plant operations director failed to identify this to the life safety surveyor and the administrator is new to the building being employed only a few months at time of the survey. Upon talking with the former plant operations director following the survey, he that stated there was mechanical ventilation in this area for years now. The plant operations assistant and adminstrator inspected the oxygen storage and transfer room and was able to validate the presence of the mechanical ventilation and that it was functioning by placing a kleenex up to the vent and having it pull and secure to the vent. Photographs were taken by the plant operations assistant to show this vent. The administrator placed a call to the ISDH Life Safety Division on 1/23/14 leaving a message and again a few days later leaving a second message asking for someone to return our call and informing them of the above information and we had pictures to validate. (Exhibit C).II. All residents, staff and visitors in the area of the physical therapy area have the potential to be affected. The facility did in fact have mechanical ventilation unit provided and functioning in the oxygen storage and transfer room at the time of the survey. The plant operations director failed to identify this to the life safety surveyor and the administrator is		

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			<p>new to the building being employed only a few months at time of the survey. Upon talking with the former plant operations director following the survey, the plant operations assistant and adminstrator inspected the oxygen storage and transfer room and was able to validate the presence of the mechanical ventilation and that it was functioning by placing a kleenex up to the vent and having it pull and secure to the vent. Photographs were taken by the plant operations assistant to show this vent. The administrator placed a call to the ISDH Life Safety Division on 1/23/14 leaving a message and again a few days later leaving a second message asking for someone to return our call and informing them of the above information and we had pictures to validate. (Exhibit C).III. No corrective action could be taken as mechanical ventilation was already present and functioning at the time of the survey. Continued Preventative Maintenance Programming and monitoring will be continued to validate functioning of the ventilation system in the oxygen storage and transfer room.IV. No corrective action could be taken as mechanical ventilation was already present and functioning at the time of the survey. Continued Preventative Maintenance Programming and monitoring will be continued to validate</p>		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 generators serving as the alternate source of power was maintained and capable of operating at full capacity. NFPA 101, 4.6.12 requires equipment required for compliance with the provisions of the Code shall be continuously maintained. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Generator Inspection Reports in the Life Safety Reports book on 01/22/14 at 9:35 a.m. with the Plant Operations Director present, in the remarks section of the "Nixon" annual generator inspection report dated 10/28/13 the following was stated: "Need to replace belts, block heater, coolant, temperature sensor and hoses." Based on interview at the time of record review, the Plant Operations Director said the items have not yet been corrected.</p>	K010144	<p>functioning of the ventilation system in the oxygen storage and transfer room.</p> <p>It is the practice of this facility to ensure generators are inspected weekly and exercised under load for 30-minutes per month in accordance with NFPA 99. 3.4.4.1. Recommended repairs from the inspection report dated 10/28/13 have been scheduled to be completed by Nixon Power Services on or before February 21, 2014-exact date cannot be determined at this time-awaiting parts delivery to vendor (Exhibit D). Plant Operations Director has been terminated effective 1/22/14.II. All residents, staff and visitors have the potential to be affected. Recommended repairs from the inspection report dated 10/28/13 have been scheduled to be completed by Nixon Power Services on or before February 21, 2014 (Exhibit D). Plant Operations Director has been terminated effective 1/22/14. Desk review compliance has been requested, the facility can submit the service completion report to the ISDH Life Safety Division upon completion of the repairs via mail or fax to validate compliance for these repairs.III. Monthly inspection reports,</p>	02/21/2014			

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K010154 SS=C	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 83 of 83 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire</p>	K010154	<p>preventative maintenance reports/logs will be reviewed monthly by the plant operations director or designee and the administrator or designee to validate compliance and ensure recommended repairs have been completed timely. This review will be ongoing.IV. Monthly inspection reports, preventative maintenance reports/logs will be reviewed in the QA meeting monthly x 6 months or until 100% compliance is achieved.</p> <p>It is the practice of this facility to ensure when a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.11. An Addendum to our current fire watch policy has been completed to include the contact information for ISDH, the local fire department and the facility's</p>	02/21/2014	

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	<p>department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors at the time of this survey.</p> <p>Findings include:</p> <p>Based on review of the Disaster Preparedness Manual on 01/22/14 at 10:30 a.m. with the Plant Operations Director present, the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy did not include information to contact Indiana State Department of Health, the local fire department, and the facility's insurance carrier with phone numbers included for each. The lack of this documentation was acknowledge by the Plant Operations Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>insurance compnay with phone number included for each (Exhibit E).II. All residents, staff and visitors have the potential to be affected. An Addendum to our current fire watch policy has been completed to include the contact information for ISDH, the local fire department and the facility's insurance compnay with phone number included for each (Exhibit E). III. Addendum has been completed to the fire watch policy-no ongoing measures required to be put into place as this is a one time correction. Staff will be inserviced over the fire watch policy, with the addendum included (Exhibit E).IV. Addendum has been reviewed and approved by the facility Safety and QA Committee's. No ongoing monitoring is required as addendum to policy is a one time change. Review will be completed during annual Policy and Procedure review and approvals.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2014	
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K010155 SS=C	<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 a complete written policy for the protection of 83 of 83 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all</p>	K010155	<p>It is the practice of this facility to ensure that when 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. 9.6.1.8I. An Addendum to our current fire watch policy has been completed to include the contact information for ISDH, the local fire department and the facility's insurance compnay with phone number included for each (Exhibit E)II. All residents, staff and visitors have the potential to be affected. An Addendum to our current fire watch policy has been completed to include the contact information for ISDH, the local fire department and the facility's insurance compnay with phone number included for each (Exhibit E)III. Addendum has been completed to the fire watch policy-no ongoing measures required to be put into place as this is a one time correction. Staff</p>	02/21/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2014
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	<p>occupants in the facility including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the Disaster Preparedness Manual on 01/22/14 at 10:30 a.m. with the Plant Operations Director present, the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy did not include information to contact Indiana State Department of Health and the local fire department with phone numbers included for both. The lack of this documentation was acknowledge by the Plant Operations Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>will be inserviced over the fire watch policy, with the addendum included (Exhibit E).IV.</p> <p>Addendum has been reviewed and approved by the facility Safety and QA Committee's. No ongoing monitoring is required as this is a one time policy change. Review will be completed during annual Policy and Procedure review and approvals.</p>		