

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155519	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
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NAME OF PROVIDER OR SUPPLIER GENTLE CARE OF VINCENNES	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST VINCENNES, IN 47591
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K 0000 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: 03/14/16</p> <p>Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370</p> <p>At this Life Safety Code survey, Gentle Care of Vincennes 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 with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms which were also addressable to the fire alarm system</p>	K 0000	<p>K000 This plan of correction is submitted to serve as an allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the allegations or conclusions set forth in the statement of deficiencies. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We request that our plan of correction be considered our allegation of compliance effective April 13, 2016.</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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K 0029 SS=F Bldg. 01	<p>via a wireless system. The facility has a capacity of 60 and had a census of 40 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, except two detached wood sheds used for facility storage.</p> <p>Quality Review completed on 03/17/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous area doors, such as a kitchen door, closed completely and latched into its door frame. Doors to hazardous areas are required to automatically latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect all residents, as well as staff and visitors while in the dining room.</p>	K 0029	<p>K029 1) Corrective Actions for Residents Found to Have Been Affected Current Residents were found not to have been affected.</p> <p>2) Identification of Residents Having the Potential to Be Affected: Administrator identified</p>	04/13/2016

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	<p>Findings include:</p> <p>Based on observation on 03/14/16 at 10:38 a.m. during a tour of the facility with the Maintenance Supervisor, the kitchen door to the dining room was equipped with a self closing device, however, the door would not close completely when tested because the built on shelf on the dining room side of the door was sticking to the door frame and leaving a three inch gap between the door and door frame when closed fully. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3-1.19(b)</p>		<p>allresidents as having the potential to be affected. The Maintenance Supervisor corrected thepractice (4/13/16) by adjusting the kitchen door to the dining room. The adjustment allows the door to close fullyand latch in the door frame, keeping the door tightly closed.</p> <p>3) Measures orSystemic Changes to Ensure Practice Does Not Recur: The Facility will add item#10; <u>Kitchen door to dining room automatically closes and latches in doorframe</u>, to the "Weekly Maintenance Review of Fire Safety". (Exhibit A)The Maintenance Supervisor will inspect the kitchen door to the dining roomweekly to ensure the door closes automatically and latches securely in theframe. Results of the inspection will berecorded on the "Weekly Maintenance Review of Fire Safety, item #10. (Exhibit A)</p> <p>4) CorrectiveActions</p>		

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			<p>Monitored: The Maintenance Supervisor will complete the "Weekly Maintenance Review of Fire Safety" (Exhibit A) and submit the completed inspection document to the Administrator for review and signature. The Administrator will report the results of the "Weekly Maintenance Review of Fire Safety" to the monthly Quality Improvement Committee (CQI).</p> <p>The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The Committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The Committee also assists in the development and initiation of plans of correction related to identified problems. CQI</p>	

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K 0046 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 8 of 8 interior battery powered light sets were tested monthly for 30 seconds and annually for 90 minutes, furthermore, the facility failed to ensure 7 of 7 exterior battery powered light sets were tested 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. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the</p>	K 0046	<p>evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.</p> <p>K046 1) Corrective Actions for Residents Found to Have Been Affected: Current residents were found not to have been affected.</p> <p>2) Identification of Residents Having the Potential to be Affected: The Administrator identified all residents as having the potential to be affected. The facility created an "Exterior Monthly Battery Powered Light Test" log (Exhibit B) to verify testing 7 of 7 exterior battery powered</p>	04/13/2016

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	<p>authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) 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 annual emergency battery powered light documentation on 03/14/16 at 10:25 a.m. with the Maintenance Supervisor present, there was no documentation to show the eight interior battery back up light sets were tested monthly during the past twelve months, plus, there was no documentation to show the eight interior battery back up light sets were tested for ninety minutes annually during the past twelve months, furthermore, there was no documentation to show the seven exterior battery back up light sets were tested monthly during the past twelve months. Based on observation at the time of record review, the Maintenance Supervisor said all battery back up lights sets are tested monthly, but acknowledged there was no testing documentation available.</p> <p>3-1.19(b)</p>		<p>lights for a 30 second duration. The facility also created an "InteriorMonthly Battery Powered Light Test" log (Exhibit C) to verify testing 8 of 8interior battery powered light sets for a 30 second duration. The facility created an "Interior AnnualBattery Powered Light Test" log (Exhibit D) to verify testing 8 of 8 interiorbattery powered light sets for a 90-minute duration. The facility also created an "Exterior AnnualBattery Powered Light Test" log (Exhibit E) to verify testing 7 of 7 exteriorbattery powered light sets for a 90-minute duration.</p> <p>3)Measures or Systemic Changes to Prevent Recurrences: Maintenance Supervisor willcomplete "Exterior Monthly Battery Powered Light Test" log (Exhibit B) and"Interior Monthly Battery Powered Light Test" log (Exhibit C) every 30 days. TheMaintenance Supervisor will complete the "Interior</p>	

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			<p>Annual Battery Powered LightTest” log (Exhibit D) and the “Exterior Annual Battery Powered Light Test” log(Exhibit E) within a twelve-month period.</p> <p>4) Corrected Action Monitored: The Maintenance Supervisor will submit the above mentioned logs (Exhibits B, C, D & E) to the Administrator for review and signature. The Administrator will report the results of the “Exterior Monthly Battery Powered Light Test” (Exhibit B), the “Interior Monthly Battery Powered Light Test” (Exhibit C), the “Interior Annual Battery Powered Light Test(Exhibit D) and the “Exterior Annual Battery Powered Light Test” (Exhibit E) to the monthly Quality Improvement Committee (CQI). The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of</p>	

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K 0056 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Based on observation and interview, the	K 0056	assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The Committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The Committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.	04/13/2016	

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	<p>facility failed to insure 1 of 4 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect mostly staff while in the main level employee break room/conference room.</p> <p>Findings include:</p> <p>Based on observation on 03/14/16 at 11:15 a.m. during a tour of the facility with the Maintenance Supervisor, there were two sprinkler heads within four feet of each other in the main level employee break room/conference room. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>1. Corrective Actions for Residents Found to Have Been Affected: Current residents were found not to have been affected.</p> <p>1. Identification of Residents Having the Potential to be Affected: The administrator identified all those utilizing the Conference/Employee Break Room as having the potential to be affected by the practice. To correct the practice, the Maintenance Supervisor contacted the facility sprinkler system contracted service to remove one of the sprinklers in order to meet the requirement, that no two sprinklers be closer than six feet to each other. (Exhibit F)</p> <p>1. Measures or Systemic Changes to Ensure Practice Does Not Recur: One of the sprinklers was removed (date) so that two sprinklers are not closer than six feet to each other. Inspection of the sprinklers and the six-foot distance requirement will be added to the "Weekly Maintenance Review of Fire Safety" (Exhibit A) item #13, <u>all sprinklers are at least 6 feet apart.</u> The Maintenance Supervisor will complete the "Weekly Maintenance Review of Fire Safety" and record the inspection results.</p> <p>1. Corrective Actions Monitored:</p>		

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			The Maintenance Supervisor will complete the "weekly Maintenance Review of Fire Safety" (Exhibit A) and submit the completed inspection document to the Administrator for review and signature. The Administrator will report the results of the "Weekly Maintenance Review of Fire Safety" (Exhibit A) to the monthly Quality Improvement Committee (CQI). The Role of the CQI Committee (per facility Policy and Procedure) is to establish and conduct an extensive and objective program of assessment, reporting and monitoring in order to assure provision of optimal services in regard to resident care, satisfaction and quality of life. The Committee is responsible for identifying and monitoring areas that require prevention and corrective actions. The Committee also assists in the development and initiation of plans of correction related to identified problems. CQI evaluates the results of the plans as well. The CQI Committee meets monthly with the findings reported to the quarterly Quality Assurance Committee.		