STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 07/19/16 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 At this Life Safety Code survey, Catherine Kasper Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of Type II (000) 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 detectors in the resident rooms. The facility has a capacity of 81 and had a census of 70 at the time of this survey.	K 0000	Please accept this Plan of Correction as our credible allegation of compliance. Submission of this Plan of Correction does not constitute admission of the allegations contained in the CMS-2567 for survey event ID 4MUR21, for July 19, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/22/16 - DA			
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 2nd floor Clean Linen room smaller than 50 square feet was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment	K 0017	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. A new electrical smoke detector was installed in Clean Linen Room on 2nd floor. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and up to 37 residents. Findings include: Based on an observation with the Maintenance Technician #1 on 07/19/16 at 11:14 a.m., there was a two inch gap at the top of the sliding corridor doors for the 2nd floor Clean Linen room. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the 2nd floor Clean Linen room was not protected by an electrically supervised automatic smoke detection system. Based on an interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)		the building will be completed by Maintenance to ensure smoke detectors are in place where needed. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be in-serviced on proper placement of smoke detectors. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor smoke detectors monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0018	NFPA 101			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 01	LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance office corridor doors did not have an impediment to latching. This deficient practice could affect staff only. Findings include: Based on observation and interview on 07/19/16 at 2:38 p.m., the Maintenance Technician #1 acknowledged the corridor door to the Maintenance office door was held open by a piece of wire which prevented the corridor door from closing and latching into the door frame.	K 0018	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. a.Wire has been removed from Maintenance Door 7/19/16. b. Rooms 022, 012, 020, 026, AHU#1 door closer and latching device have been added to doors. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a.An audit of facility doors will be completed to ensure there are no impediments on doors to prevent proper latching. b. An audit of facility doors will be completed to ensure	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 5 of 18 Lower Level rooms positively latched into the door frame. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 07/19/16 between 1:20 p.m. to 1:56 p.m., the following was discovered: a) The Mechanical room 022 did not have positively latching hardware installed. b) The Maintenance room double doors latched into each other but did not have positively latch into the frame. c) The Boiler room 020 double doors latched into each other but did not have positively latch into the frame. Additionally, both doors had door stops installed. d) The Basement Storage AHU #1 room double doors latched into each other but did not have positively latch into the frame. e) The Cleaning room 026 double doors latched into each other but did not have positively latch into the frame. Based on interview at the time of each		that all doors latch properly. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. **a. All staff** will be in-serviced on doors for proper latching and the use of impediments. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. a.Maintenance or designee will monitor all doors for any impediments and proper latching monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation, the Maintenance Technician #1 acknowledged each aforementioned condition. 3.1-19(b)			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observations with the Maintenance Technician #1 on 07/19/16 at 1:48 p.m., there were three ceiling tiles missing in the Wellness Room. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition.	K 0025	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Ceiling tile have been replaced per maintenance on 7/19/16. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of all ceiling tile will be completed to ensure there are no other missing ceiling tile in facility. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. **Maintenance staff** will be in-serviced on replacement of ceiling tile to maintain 1/2 hour fire rating. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur.	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		Maintenance or designee will monitor all facility ceiling tile monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Kitchen and 1 of 1 Generator room, both hazardous areas, was provided with a self-closer and would positively latch into the frame. This deficient practice could affect staff and up to 22 residents. Findings include: Based on observation with the Maintenance Technician #1 on 07/19/16 at 12:10 p.m. then again at 1:25 p.m., a set of double doors latched into each other but neither of the doors latched into	K 0029	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Dining Room and Generator doors now latch to frame, installed electronic strikes into existing jamb. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All doors that enter to hazardous will be audited for self-closer by Maintenance or designee. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the frame in the Kitchen. Then again, a set of double doors latched into each other but neither of the doors latched into the frame in the Generator room. Additionally, one of the doors had a manual latch and failed to self-close when tested. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)		inseviced on doors that enter to hazardous areas for self closer. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will audit door closers monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents. Findings include:	K 0050	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. A new Fire Drill Schedule was developed for the rest of 2016 and for the year 2017 Completed on 7/28/16. 2.How other residents having potential to be affected by	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review of the "Fire Drill Log" forms with the Maintenance Technician #1 on 07/19/16 at 10:56 a.m., three sequential first shift fire drills took place between 1:25 p.m. and 1:45 p.m. for three of the last four quarters. Then again, three sequential second shift fire drills took place between 2:35 a.m. and 3:00 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		the same deficient practice will be identified and what corrective action will be take. Fire Drills will be reviewed by Administrator for proper fire drill times monthly. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance or designee will be in-serviced on time of fire drills and reports to Administrator every month. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor Fire Drills for proper times monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0051 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the 2nd floor Soiled Utility and 1 of 1 smoke detector in the Dietary Break room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 07/19/16 at 11:11 a.m. then again at 12:04 p.m., the 2nd floor Soiled Utility room had a smoke detector located fifteen inches away from an HVAC vent. Then again, the Dietary Break room had a smoke detector located ten inches away from an HVAC vent. Based on interview at the time of each observation, the	K 0051	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Smoke detectors moved in second floor soiled utility room and first floor kitchen break room to accommodate proper air flow. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of the building will be completed by Maintenance to ensure smoke detectors are in place to assure proper air flow. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be in-serviced on proper placement of smoke detectors for air flow. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor smoke detectors monthly times three months, Audits will be presented to Quality Assurance	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Technician #1 acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)		Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0068 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry room was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could affect staff only. Findings include: Based on an observation with the Maintenance Technician #1 on 07/19/16 at 1:46 p.m., the laundry room had fuel fired dryers with no fresh air intake. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0068	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Air Handler Unit 5(AHU) is the Catherine Kasper make up air unit brings in 100% fresh outside air and tempers air by passing it through chilled coils in the summer and heating in the winter please see graphic The laundry room in question receives this 100% outside air 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. System is working no one is affected 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. System is on a preventive maintenance program 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor monthly Date of	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Compliance 8/11/16	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 5 stairwells. This deficient practice could affect staff, visitors, and at least 16 residents Findings include: Based on observations with the Maintenance Technician #1 on 07/19/16 at 11:04 a.m., a cardboard box filled with air conditioner filters was stored at the top of the center stairwell. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0072	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Obstruction has been removed from stairwell and signs posted "No Storage in This Area" on 7/19/16. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of the building will be completed by Maintenance to ensure stairwell are free from obstructions. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. All staff will be in-serviced maintaining egress free from obstruction. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor stairwells for obstructions monthly times three months, Audits will be presented	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	
K 0130 SS=D Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to maintain 1 of 1 laundry linen chute. LSC 4.6.12.1 requires whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 07/19/16 at 11:02 a.m., the second floor laundry chute door left a quarter inch gap when tested. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0130	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Door was serviced and now closes / latches. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of the building will be completed by Maintenance to ensure there are no gaps in laundry chute doors. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be in-serviced on proper latching of laundry chute doors. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur'. Maintenance or designee will monitor laundry chute doors monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Maintenance Technician #1 on 07/19/16 at 10:40 a.m., the generator log form	K 0144	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Facility added a column to Generator log sheet for cool down period 8/9/16. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of Generator Log and documentation for cool down period will be initialed per Administrator monthly. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be in-serviced on documentation for generator log, cooled down period. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor generator log sheet for cool down period monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. 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 affects staff and up to 37 residents. Findings include: Based on observation with the Maintenance Technician #1 on 07/19/16 at 11:49 a.m. then again at 1:40 p.m., a	K 0147	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Oxygen concentrator has been removed from surge protector and plugged into wall electrical outlet. Extension cord removed from room. 2.How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of the building will be completed by Maintenance to ensure medical devices are plugged directly into electrical wall unit. An audit of the building will be completed by Maintenance to ensure no extension cords are used in building. 3. What measures will	08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	surge protector was powering an oxygen concentrator in resident room 286. Then again, an extension cord was powering a sump pump in the Kasper exhaust room. Based on interview at the time of each observation, the Maintenance Technician #1 acknowledged each aforementioned condition. 3.1-19(b)		be put into place or systemic changes will be made to ensure that the deficient practice does not recur. All staff will be in-serviced on proper procedures used to plug in medical equipment and extension cords are to be used in building. 4.How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor medical equipment for proper electrical outlets and any use of extension cords, monthly times three months, Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 8/18/16	