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	08/26/2016

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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/19/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/26/16 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 At this PSR survey, Catherine Kasper Home was found in substantial 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.	K 0000	Please accept this Plan of Correction as our credible allegation of compliance. Submission of this POC does not constitute admission of the allegations contained in the CMS-2567 for survey event ID 4MUR22, for August 26,2016	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The facility has a capacity of 81 and had a census of 75 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/30/16 - DA			
K 0018 SS=B Bldg. 01	NFPA 101 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 Based on observation and interview, the facility failed to ensure 1 of 1 Cleaning room 026 would coordinate the closing of the set of doors properly when tested.	K 0018	1.What corrective action will be accomplished for those residents found to have been affected by this practice. This would only affect staff, doors to room 026	09/25/2016

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	This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 08/26/16 at 9:18 a.m., the Cleaning room 026 double doors contained an astragal. A coordinating device was not installed to prevent from the astragal installed door from closing last. Based on interview at the time of each observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 07/19/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		have been repaired to coordinate proper closing. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. This would only affect staff, audits of doors will be completed by maintenance. 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 trained on proper door closing. 4. How the corrective action will be monitored to ensure that the deficient does not recur. Maintenance or designee will monitor all doors for proper latching monthly times three months. Audits will be presented to Quality Assurance Committee for review until 100% compliance is achieved. Date of Compliance 9/25/16	
K 0147 SS=B 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 1 of 1 flexible cord was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article	K 0147	1.What corrective action will be accomplished for those residents found to have been affected by this practice. Concentrator was unplugged from surge plug. 2.How other residents having the	09/25/2016

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	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 08/26/16 at 9:07 a.m., a surge protector was powering an oxygen concentrator in resident room 286. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 08/26/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit of rooms with concentrators and surge plugs was completed to ensure no medical equipment was plugged into a extension cord or surge plug. Re-arrangement of electrical devices in room 286 has been conducted to reassure that an emergency receptacle is available for medical equipment. 3.What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. Staff was inserviced on use of power strips and not to plug into power strips. 4. How the corrective action will be monitored to ensure that the deficient practice does not recur. Maintenance or designee will monitor all medical equipment for proper electrical outlets being used. Audits will be done monthly times three months and the reviewed by Quality Assurance Committee for 100% compliance.	