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	154014	A. BUILDING _____ B. WING _____	12/05/2024

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OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	9 PEQUIGNOT DR PIERCETON, IN 46562

(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
A 000	INITIAL COMMENTS This visit was for a Federal Psychiatric Hospital Recertification survey. Facility Number: 005179 Survey Dates: 12/04/24-12/5/2024 and 12/6/2024 QA: 12/11/2024	A 000		
A 654	UTILIZATION REVIEW COMMITTEE CFR(s): 482.30(b) A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1). (1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following: (i) A staff committee of the institution; (ii) A group outside the institution-- (A) Established by the local medical society and some or all of the hospitals in the locality; or (B) Established in a manner approved by CMS. (2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section. (3) The committee or group's reviews may not be conducted by any individual who--	A 654		1/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/17/2025

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A 654	Continued From page 1 (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or (ii) Was professionally involved in the care of the patient whose case is being reviewed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure the doctors of medicine on the review committee did not have direct patient involvement of the patient cases being reviewed. (MD4, Doctor of Medicine) Findings Include: 1. Facility Utilization Management Plan included MD4 as one of two doctors of medicine on the Utilization Review Committee. 2. In interview on 12/05/24 at approximately 1:08 pm, A2 (Vice President [VP] Healthcare Quality) confirmed MD4 is the primary physician for facility inpatient services and is one of two physicians on the Utilization Review Committee. A2 confirmed MD4 has reviewed patient cases that MD4 provided care in the previous 4 quarters.	A 654		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least	A 700		2/24/25

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A 700	Continued From page 2 annually; failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months; failed to document a 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110; failed to exercise the generator annually to meet the requirements of NFPA 110; failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually; failed to ensure 1 of 1 kitchen exhaust systems were inspected semiannually; failed to ensure that a complete automatic sprinkler system or documentation of fire-retardant material was provided for 1 of 1 canvas canopies; failed to ensure 1 of 1 automatic sprinkler piping systems were examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25; failed to ensure 8 of 8 patient sleeping room doors had no impediment to closing and latching into the door frame and would resist the passage of smoke; failed to provide a written plan that addressed all components in 1 of 1 written fire plans; failed to conduct fire drills on each shift for 2 of 4 quarters; and failed to ensure annual inspection and testing of 2 of 2 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Findings Include: The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a)	A 701		1/17/25

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A 701	Continued From page 3	A 701		

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces).

Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written

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A 701	Continued From page 4	A 701		

record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction.

Based on record review, observation, and interview; the facility failed to document a 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load.

Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the

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A 701	Continued From page 5 manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Findings Include: Based on observation with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, 3 of 8 resident sleeping rooms contained non-hospital grade electrical receptacles. Based on record review and interview no documentation of annual testing per NFPA 99, Receptacle Testing requirements was available for review at the time of survey. Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation of monthly generator load testing was available for March 2024 or April 2024; documentation of monthly generator load tests for June 2024, July 2024, and August 2024 only stated "Pass" with no other information available. Based on an interview at the time of record review, the Facilities Director stated the facility contracts the service and acknowledged the	A 701		

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A 701	Continued From page 6 missing and incomplete documentation. Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation of a thirty-six-month period emergency generator load test for four continuous hours for the diesel emergency generator was available for review. Based on interview at the time of record review, the Facilities Director stated the facility contracts the generator service and acknowledged no documentation was available at the time of survey. Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. on 12/05/24, the load percentage recorded on May 22, 2024, was 10 percent, the load percentage recorded on February 22, 2024, was 15 percent, the load percent recorded on October 18, 2024, was 5 percent. Based on interview at the time of record review, the Facilities Director acknowledged the documentation and stated, "I would dispute the load percentage."	A 701		
A 709	LIFE SAFETY FROM FIRE CFR(s): 482.41(b) Life Safety from Fire This STANDARD is not met as evidenced by: Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a	A 709		2/24/25

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constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every six months.

Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substances. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises.

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Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 canvas canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.

Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material.

Based on observation and interview, the facility failed to ensure 8 of 8 patient sleeping room doors had no impediment to closing and latching into the door frame and would resist the passage

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of smoke. LSC section 19.3.6.3.5 states: Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply:
(1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.
(2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.

Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:
(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire

Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

Based on observation, records review, and

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interview, the facility failed to ensure annual inspection and testing of 2 of 2 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.
NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:
(1) No open holes or breaks exist in surfaces of either the door or frame.
(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.
(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of

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A 709	Continued From page 11 damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. Findings Include: Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. and on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, documentation was available of a service and inspection of the kitchen fire suppression system completed on 3/13/24; however, no documentation of any maintenance or inspection six months after was available for review. Based on observation with the Facilities Director, the kitchen contained a fire suppression system. Based on interview at the time of record review, the Facilities Director stated documentation was not available at the time of survey.	A 709		

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Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, documentation of the kitchen hood exhaust system cleaning or inspection was not available during the past twelve months. Based on interview at the time of record review, the Facilities Director said no documentation of the kitchen hood exhaust system cleaning or inspection was available at the time of survey.

Based on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, there was a canvas canopy in excess of 4 feet in width not sprinkled and attached to the building outside of the kitchen and service entrance. Based on interview at the time of observation the Facilities Director acknowledged there was no sprinkler coverage for the canopy.

Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation was available to show that an internal pipe inspection had been completed in the past five years. Based on interview with the Facilities Director at the time of record review, he stated there was no documentation for an internal pipe inspection available at the time of survey.

Based on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, none of the patient sleeping rooms were provided with a latching device. Based on interview at the time of exit, the CEO/President stated the requirement for latching patient sleeping room doors in the in-patient facility was an issue the facility had discussions about from

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	154014	A. BUILDING _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	9 PEQUIGNOT DR PIERCETON, IN 46562

(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
A 709	Continued From page 13	A 709		

previous surveys and he believed there was a conflict in requirements with different authorities.

Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the fire safety plan titled "Fire" failed to provide all of the required information. The plan failed to address: Transmission of alarm to fire department, Isolation of fire, or Extinguishment of fire. Based on interview with the Director of the In-Patient Unit, when asked if the document provided was the fire safety plan or if there was anything additional to the fire safety plan, she stated the policy provided was the only plan.

Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the following shifts were missing documentation of a completed fire drill: a) A first shift fire drill in the second quarter of 2024. b) A second shift fire drill in the third quarter of 2024. Based on interview at the time of record review, the Facilities Director stated no additional documentation of fire drills was available.

Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no annual inspection of the fire door assemblies for Room 503 identified as "Linen Supply" and Room 502 identified as "Laundry Room" were available for review. Based on observation from 1:47 p.m. to 3:00 p.m. on 12/05/24, the fire door assemblies were in a two hour fire barrier. Based on interview at the time of records review, the Facilities Director acknowledged an annual inspection was not conducted for the fire door assemblies in the

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A 709	Continued From page 14 last year and confirmed the doors were in a two hour fire barrier as identified in the floor plan provided by the facility.	A 709		