STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	154014	A. BUILDING 00 B. WING	06/04/2021

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

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A 0000 Bldg. 00	The visit was for a Federal Hospital re-certification and a focused Infection Control survey. Facility Number: 005179 Survey Date: 6/1-4/21 The Otis R Bowen Center for Human Services was found in compliance with the CMS Focused Infection Control Survey for Acute and Continuing Care. QA: 6/11/21	A 0000		
A 0178 Bldg. 00	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed practitioner; or - Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section. Based on document review and interview, the facility failed to ensure a face-to-face assessment of a patient was conducted within 1 hour of an emergency safety intervention (ESI) involving the use of restraint or seclusion for 2 of 10 patient medical records (MR) reviewed (Patients #31 & 32).	A 0178	Responsible: Director of Inpatient Operations Plan: The Inpatient Leadership team have scheduled a meeting for Tuesday, June 29, 2021 to review and update the current	07/03/2021

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

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	Findings include: 1. Review of the policy #4-502 Seclusion Restraint of Inpatient Clients (approved 10-20) indicated the following: "Advanced Practice Nurse (APN) ...[is] privileged at Bowen Center to evaluate client in seclusion/restraint ...[and the] ...Qualified Registered Nurse (QRN) ...is also privileged to evaluate client in seclusion/restraint for the one hour face-to-face evaluation ....the Physician/APN shall evaluate the client based on a face-to-face performed either by the Physician/APN or QRN to determine the need for seclusion or restraint within one (1) hour of the initiation of seclusion/restraint." 2. Review of the MR for Patient #31 indicated a manual restraint/therapeutic hold was ordered and initiated on 2-7-21 at 0820 hours after the Registered Nurse N11 observed the patient during a self-harming behavior and attempts to verbally de-escalate the patient's self-harming behavior by the staff were ineffective. The MR for Patient #31 indicated a new order to initiate 4 point physical restraints was implemented on 2-7-21 at 0830 hours after the patient began attempting to harm the ESI staff and lacked documentation indicating a face-to face evaluation was performed by a Physician, APN or QRN within one hour of initiating the manual restraint. 3. Review of the MR for Patient #32 indicated a manual restraint/therapeutic hold was ordered and initiated on 2-8-21 at 1640 hours after the Registered Nurse N11 observed the patient during a self-harming behavior and attempts to verbally de-escalate the patient's self-harming behavior by the staff were ineffective. The MR for Patient #32 indicated a new order to initiate 4 point physical		Seclusion and Restraint packet to make the form more intuitive and user friendly for staff. Once updates are made and vetted through end users, training will be provided to staff and the new form implemented. To ensure compliance, the IPU Quality Assurance Specialist will audit 100% of Seclusion and Restraint packets to ensure a face-to-face assessment of a patient was conducted within 1 hour of an emergency safety intervention (ESI) involving the use of restraint or seclusion. The IPU Quality Assurance Specialist will report audit results to the Inpatient Unit Utilization Management Committee monthly. If audit results are showing non-compliance, additional individualized training will be conducted with staff.	

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	restraints was implemented on 2-8-21 at 1705 hours after the patient began attempting to harm the ESI staff and lacked documentation indicating a face-to face evaluation was performed by a Physician, APN or QRN within one hour of initiating the manual restraint. 4. On 6-2-21 at 1715 hours, the IPU (inpatient unit) Operations Director A3 and the IPU Quality Assurance Specialist A7 confirmed the ESI restraint documentation for the two patients failed to indicate a face-to-face evaluation was performed within one hour of initiating the intervention.			
A 0182 Bldg. 00	482.13(e)(14) PATIENT RIGHTS: RESTRAINT OR SECLUSION If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse, the trained registered nurse must consult the attending physician or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation. Based on document review and interview, the facility failed to ensure the attending physician was consulted after a one hour face-to-face evaluation was performed during an emergency safety intervention (ESI) involving the use of restraint or seclusion for 2 of 10 patient medical records (MR) reviewed (Patients #31 & 32). Findings include: 1. Review of the policy #4-502 Seclusion Restraint of Inpatient Clients (approved 10-20) indicated the following: "Advanced Practice Nurse (APN) ...[is] privileged at Bowen Center to evaluate client in	A 0182	Responsible: Director of Inpatient Operations Plan: The Inpatient Leadership team have scheduled a meeting for Tuesday, June 29, 2021 to review and update the current Seclusion and Restraint packet to make the form more intuitive and user friendly for staff. Once updates are made and vetted through end users, training will be provided to staff and the new form implemented. To ensure	07/03/2021

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	seclusion/restraint ...[and the] ...Qualified Registered Nurse (QRN) ...is also privileged to evaluate client in seclusion/restraint for the one hour face-to-face evaluation ....if the QRN conducts the mandatory one hour evaluation, the QRN must consult with the attending Physician/APN as soon as possible thereafter, to provide an update on the client's status and need for seclusion or restraint." 2. Review of the MR for Patient #31 indicated on 2-7-21 at 0820 hours a manual restraint/therapeutic hold was ordered and initiated after the Registered Nurse N11 observed the patient during a self-harming behavior and attempts to verbally de-escalate the patient's self-harming behavior by staff were ineffective. The MR indicated a new order to initiate 4 point physical restraints was implemented on 2-7-21 at 0830 hours after the patient began attempting to harming the ESI staff and lacked documentation indicating the Psychiatrist MD22 was contacted after a face-to face evaluation was performed. 3. Review of patient #32's MR indicated on 2-8-21 at 1640 hours a manual restraint/therapeutic hold was ordered and initiated after the Registered Nurse N11 observed the patient during a self-harming behavior and attempts to verbally de-escalate the patient's self-harming behavior by staff were ineffective. The MR indicated a new order to initiate 4 point physical restraints was implemented on 2-8-21 at 1705 hours after the patient began attempting to harming the ESI staff and lacked documentation indicating the Psychiatrist MD22 was contacted after a face-to face evaluation was performed. 4. On 6-2-21 at 1715 hours, the IPU (inpatient unit) Operations Director A3 and the IPU Quality		compliance, the IPU Quality Assurance Specialist will audit 100% of Seclusion and Restraint packets to ensure the attending provider is being consulted after a one hour face-to-face evaluation was performed during an emergency safety intervention (ESI) involving the use of restraint or seclusion. The IPU Quality Assurance Specialist will report audit results to the Inpatient Unit Utilization Management Committee monthly. If audit results are showing non-compliance, additional individualized training will be conducted with staff.	

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	Assurance Specialist A7 confirmed the ESI restraint documentation for the two patients failed to indicate the attending Psychiatrist was consulted after the face-to-face evaluation was performed.			
A 0700 Bldg. 00	482.41 PHYSICAL ENVIRONMENT 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. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 patient emergency exits with special locking arrangements for the clinical security needs of the patients would release upon activation of the smoke detection system or the fire sprinkler system (tag K222), failed to ensure 5 of 5 hazardous areas that contained fuel fire equipment were protected with a self-closing latching door (tag K321), failed to ensure 1 of 1 fire alarm control units, located in an area that was not continuously occupied, was provided with annunciation readily accessible to responding personnel to facilitate an efficient response to the fire situation (tag K341) , failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after instillation and at least every six years in accordance with NFPA 90A (tag K521) failed to conduct fire drills on each shift for 2 of 4 quarters (tag K712), failed to maintain proper testing of 1 of 1 rolling fire door/windows in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives (tag K761) and failed to ensure 1 of 1 emergency generators was equipped	A 0700	Responsible: Director of Facilities Plan: the following tags will be addressed to bring A-0700 into compliance: K-222 The Director of Facilities has scheduled Cottage Watchman to perform an update to the fire system to ensure the 300, 400, and 500 wing exit doors unlock appropriately when there is activation of the smoke detection or sprinkler system by July 15, 2021. Once the update is complete, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance. K-321 The Director of Facilities has scheduled Carey Maintenance and Building to install automatic door	07/31/2021

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	with a properly located remote stop in the event the generator caught fire (tag K918), and failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2 (tag K711). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure a safe environment was maintained to provide quality health care for patients.		closers on Housekeeping Room 506, Housekeeping Room 303, Mechanical Room 302, Mechanical Room 302, Mechanical Room 401, and Mechanical Room 404 by July 15, 2021. Once installed, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance. K-341 The Director of Facilities has scheduled the installation of the fire remote annunciator panel in the Nurse's Station (which is continuously occupied) with Cottage Watchman. Cottage Watchman has ordered the required parts and will complete the installation once parts arrive. Due to lead time on parts, the installation will be completed by 7/31/2021. Once installed, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance. K-521 The Director of Facilities has Extinguisher Co. No. 1 to inspect the fire dampers in accordance with regulation. The contractor is scheduled to walk through the building on Tuesday, June 29th to assess the scale of the project. Once the building walkthrough is	

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			complete, the contractor will order the replacement fusible links required for inspection. Once the fusible links arrive, the contractor will complete inspections. Due to the number of dampers in the building and lead time on replacement parts, inspections will be completed by 7/31/2021. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee. K-712 The responsibility of tracking fire drill compliance has been transferred to the Facilities Department to ensure it is being done at the required frequency. Additionally, fire drill compliance will be reported to the Fire Safety Committee monthly and to the Safety and Risk Management Committee on a quarterly basis to provide additional oversight. Staff training will be provided and documented quarterly. To ensure compliance, the IPU Quality Assurance Specialist has created and implemented a competency control cycle to ensure staff receive training quarterly. K-761 The Director of Facilities will have	

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			the rolling fire door inspected by Extinguisher Co. No. 1 in accordance with NFPA 80 5.2.1 by 7/15/2021. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee annually. K-918 The Director of Facilities has scheduled Herrman and Goetz to install an emergency stop button and emergency lighting by 7/15/2021. Emergency lighting will be tested in accordance with NFPA 110 and the emergency button will be tested annually. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee. K-711 Responsible: Safety Manager Plan: The Safety Manager, in coordination with the Director of Facilities, will develop a Fire Safety Plan specific to the facility that addresses the following:	

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			·Use of alarms ·Transmission of alarm to the fire department ·Emergency phone call to fire department ·Response to alarms ·Isolation of fire ·Evacuation of immediate area ·Evacuation of smoke compartment ·Preparation of floors and building for evacuation ·Extinguishment of fire The plan will be created and implemented by July 3, 2021. To ensure the plan is reviewed and updated on an annual basis, the Assistant Director of Healthcare Quality will create and monitor a control cycle for Emergency Management planning.	
A 0710 Bldg. 00	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (b) Standard: Life safety from fire. (1) Except as otherwise provided in this section— (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient			

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	surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served. (ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors. (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 patient emergency exits with special locking arrangements for the clinical security needs of the patients would release upon activation of the smoke detection system or the fire sprinkler system, failed to ensure 5 of 5 hazardous areas that contained fuel fire equipment were protected with a self-closing latching door, failed to ensure 1 of 1 fire alarm control units, located in an area that was not continuously occupied, was provided with annunciation readily accessible to responding personnel to facilitate an efficient response to the fire situation. LSC 9.6.1.3 requires	A 0710	Responsible: Director of Facilities Plan: the following items will be addressed to bring A-710 into compliance: 1. The Director of Facilities has scheduled Cottage Watchman to perform an update to the fire system to ensure the 300, 400, and 500 wing exit doors unlock appropriately when there is activation of the smoke detection	07/31/2021

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	a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 10.16.3.1 states all required annunciation means shall be readily accessible to responding personnel. Section 10.16.3.2 states all required annunciation means shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. Section 10.12.5 states the trouble signal(s) shall be located in an area where it is likely to be heard, failed to ensure 1 of 1 fire damper systems were inspected and provided necessary maintenance after the first year after instillation and at least every six years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected, failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6		or sprinkler system by July 15, 2021. Once the update is complete, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance. 2. The Director of Facilities has scheduled Carey Maintenance and Building to install automatic door closers on Housekeeping Room 506, Housekeeping Room 303, Mechanical Room 302, Mechanical Room 302, Mechanical Room 401, and Mechanical Room 404 by July 15, 2021. Once installed, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance. 3. The Director of Facilities has scheduled the installation of the fire remote annunciator panel in the Nurse's Station (which is continuously occupied) with Cottage Watchman. Cottage Watchman has ordered the required parts and will complete the installation once parts arrive. Due to lead time on parts, the installation will be completed by 7/31/2021. Once installed, this area of non-compliance has been permanently addressed. No further action is necessary to ensure ongoing compliance.	

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	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. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area, failed to maintain proper testing of 1 of 1 rolling fire door/windows in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires 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, and failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop		4. The Director of Facilities has Extinguisher Co. No. 1 to inspect the fire dampers in accordance with regulation. The contractor is scheduled to walk through the building on Tuesday, June 29th to assess the scale of the project. Once the building walkthrough is complete, the contractor will order the replacement fusible links required for inspection. Once the fusible links arrive, the contractor will complete inspections. Due to the number of dampers in the building and lead time on replacement parts, inspections will be completed by 7/31/2021. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee. 5. The responsibility of tracking fire drill compliance has been transferred to the Facilities Department to ensure it is being done at the required frequency. Additionally, fire drill compliance will be reported to the Fire Safety Committee monthly and to the Safety and Risk Management Committee on a quarterly basis to provide additional oversight. Staff training will be provided and documented quarterly. To ensure compliance, the IPU Quality	

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	station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: 1. Based on observation with the Facilities Director and the Inpatient Director on 06/02/21 at 1:50 p.m., the inpatient area had special locking arrangements for patients with clinical security needs. The 300, 400, and 500 exit doors in the inpatient area were locked with a latch that hooked into the door frame and could be opened by a key carried by staff, but it could not determine if the doors would unlock from the door frame upon activation of the smoke detection system or sprinkler system. When the fire system was activated by a pull station the doors did not unlock. Based on interview at the time of observation, the Facilities Director stated it is unknown if the doors would unlock from the door frame if the smoke detection system or sprinkler system was activated. 2. Based on observations with the Facilities Director and the Inpatient Director on 06/02/21 between 12:55 p.m. and 2:00 p.m., the corridor doors to the following hazardous areas that contained fuel fire equipment were not self-closing: a) Housekeeping room 506. b) Housekeeping room 303. c) Mechanical room 302. d) Mechanical room 401.		Assurance Specialist has created and implemented a competency control cycle to ensure staff receive training quarterly. 6. The Director of Facilities will have the rolling fire door inspected by Extinguisher Co. No. 1 in accordance with NFPA 80 5.2.1 by 7/15/2021. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee annually. 7. The Director of Facilities has scheduled Herrman and Goetz to install an emergency stop button and emergency lighting by 7/15/2021. Emergency lighting will be tested in accordance with NFPA 110 and the emergency button will be tested annually. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee. 8. The Director of Facilities has scheduled Herrman and Goetz to install an emergency stop button and emergency lighting by 7/15/2021. Emergency lighting will be tested in accordance with	

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	154014	A. BUILDING 00 B. WING	06/04/2021

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	e) Mechanical room 404. Based on interview at the time of observations, the Facilities Director agreed all five rooms contained fuel fired equipment and the corridor doors to the rooms were not self-closing. 3. Annex A is not a part of the requirements but is included for informational purposes only Section A.10.16.3 states the primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. This deficient practice could affect all patients, staff and visitors in the facility. 4. Based on observations with the Facilities Director and the Inpatient Director on 06/03/21 at 1:01 p.m., the main fire alarm control unit was in the I.T. room and a remote annunciator was in the font foyer. Both areas are only occupied during business hours and not continuously occupied. Based on interview at the time of the observations, the Inpatient Director agreed the main panel and remote panel were not in areas continuously occupied and stated there is no remote annunciator in the continuously occupied areas of the building. 5. Based on records review with the Facilities Director and the Inpatient Director on 06/02/21 at 10:02 a.m., The facility was built and had smoke/fire dampers installed in 2015. No documentation of an inspection for the facility's smoke/fire dampers one year after installation was available for review. Based on interview at the time of records review, the Facilities Director stated the facility does have dampers in the		NFPA 110 and the emergency button will be tested annually. To ensure ongoing compliance with inspection frequency, the Assistant Director of Healthcare Quality will create and monitor a control cycle. Inspection results will be reported to the Safety and Risk Management Committee.	

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	HVAC system and the damper inspection one year after installation could not be found. 6. Based on records review with the Facilities Director and the Inpatient Director on 06/02/21 at 10:02 a.m., the following shifts were missing documentation of a completed fire drill: a) A third shift fire drill in the fourth quarter of 2020. b) A third shift fire drill in the first quarter of 2021. c) A second shift fire drill in the first quarter of 2021. Furthermore, no documentation was provided to show staff reviewed fire safety procedures for the fourth quarter of 2020 and first quarter of 2021. Based on interview at the time of record review, the Facilities Director agreed there were three missing fire drills and staff has not been trained in the fire safety procedures for the last two quarters. 7. Based on observation with the Facilities Director and the Inpatient Director on 06/02/21 at 12:07 p.m., there were non-rated wall length windows in the fire wall that were protected by a roiling fire door/window. Based on records review at 2:00 p.m., no documentation was provided to show if the roiling fire door/window has ever been inspected. Based on interview at the time of observation, the Facilities Director stated the roiling fire door/window has not been inspected since the building was built in 2015. 8. Based on observation with the Facilities Director and the Inpatient Director on 06/02/21 at 10:02 a.m., a remote emergency stop button for the diesel power generator could not be located. Based on interview at the time of observation, the Facilities Director stated the generator was not equipped with a remote emergency stop button.			

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	9. Based on observation and interview, the facility failed to ensure 1 of 1 generators were provided with battery-powered emergency lighting. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This deficient practice could affect all patients in the facility. 10. Based on observation with the Facilities Director and the Inpatient Director on 06/02/21 at 10:02 a.m., the emergency generator which was enclosed within privacy fencing did not contain battery-powered emergency lighting. Based on an interview at the time of observation, the Facilities Director stated the generator was not provided with battery-powered emergency lighting. 11. The findings were reviewed with the Facilities Director and the Inpatient Director during the exit conference.			
A 0714 Bldg. 00	482.41(b)(5) FIRE CONTROL PLANS (5) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. 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 the fire department	A 0714	Responsible: Safety Manager Plan: The Safety Manager, in coordination with the Director of Facilities, will develop a Fire Safety Plan specific to the facility that addresses the following:	07/03/2021

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	(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 This deficient practice could affect all occupants. Findings include: Based on records review with the Facilities Director and the Inpatient Director on 06/02/21 at 11:02 a.m., the provided fire emergency plan lacked information on partial or horizontal evacuation from one smoke compartment beyond a smoke or fire barrier to the next smoke compartment. Also, the plan did not identify the locations of smoke/fire door in the barriers. Based on interview during records review, the Facilities Director agreed the fire emergency plan did not contain complete instruction for evacuation of smoke compartment. The finding was reviewed with the Facilities Director and the Inpatient Director during the exit conference.		·Use of alarms ·Transmission of alarm to the fire department ·Emergency phone call to fire department ·Response to alarms ·Isolation of fire ·Evacuation of immediate area ·Evacuation of smoke compartment ·Preparation of floors and building for evacuation ·Extinguishment of fire The plan will be created and implemented by July 3, 2021. To ensure the plan is reviewed and updated on an annual basis, the Assistant Director of Healthcare Quality will create and monitor a control cycle for Emergency Management planning.	
A 0715 Bldg. 00	482.41(b)(6) REGULAR FIRE AND SAFETY INSPECTIONS (6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies. Based on document review and interview, the facility's inpatient unit (IPU) failed to maintain documentation of regular fire inspections by the State or local fire control agencies for one occurrence.	A 0715	Responsible: Director of Facilities Plan: The Director of Facilities has reached out to several organizations to schedule a state or local fire inspection.	07/15/2021

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	Findings include: 1. Review of the policy #3-413 Safety Inspections (approved 2-20) and the Fire Safety Management Plan (approved 10-19) lacked an indication for conducting regular fire safety inspections of the inpatient unit by a State or local fire control agency. 2. On 6-2-21 at 1715 hours, the IPU Operations Director A3 was requested to provide documentation indicating the most recent State and/or local fire inspection of the inpatient unit and none was provided prior to exit. 3. On 6-3-21 at 1235 hours, staff A3 indicated the most recent fire inspection of the IPU was conducted in 2018 and confirmed no documentation of an IPU fire inspection in 2019, 2020 and/or 2021 was available.		Correspondence to show this effort has been uploaded as supporting documentation. The organization has been in contact with Joe Fretz via phone, who is the fire marshal for Warsaw-Wayne fire territory. Joe Fretz is seeking approval to do the inspection because the facility is out of his jurisdiction, but once approval is granted, Joe will complete the inspection. The organization has also scheduled an appointment with State Fire Marshal Joel Thacker to discuss getting the inspection done. The appointment with Joel Thacker is scheduled for Tuesday, June 29, 2021. To ensure compliance, the Assistant Director of Healthcare Quality will create and monitor a control cycle for required inspection frequency. Results from inspections will be reported to the Safety and Risk Management Committee.	