| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155668 | A. BUILDING -- B. WING | 07/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| DIVERSICARE OF PROVIDENCE | 4915 CHARLESTOWN RD NEW ALBANY, IN 47150 |

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| E 0000<br><br>Bldg. -- | A Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 07/26/22<br><br>Facility Number: 001144<br>Provider Number: 155668<br>AIM Number: 200256980<br><br>At this Emergency Preparedness survey, Diversicare of Providence was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73.<br><br>The facility has 172 total beds with 158 certified beds. At the time of the survey, the census was 131. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living areas.<br><br>Quality Review completed on 07/26/22 | E 0000 | Allegation of Compliance<br><br>Please accept the following plan of correction for the annual survey completed on July 26, 2022.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.<br><br>We respectfully request consideration for a desk review and paper compliance. | |
| E 0041<br>SS=C<br>Bldg. -- | 482.15(e), 483.73(e), 485.625(e)<br>Hospital CAH and LTC Emergency Power<br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) | | | |

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

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| | (i) and (ii) of this section.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at | | | |

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| | §483.73(g), and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011. | | | |

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| | (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2).<br><br>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 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. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 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, staff and visitors. | E 0041 | 1. The emergency generator load test log includes a 5 minute cool down time, last generator load test completed on 8/5/2022.<br>2. All residents of the Center have the potential to be affected.<br>3. The maintenance director was educated by the administrator on completing the monthly load test logs and maintaining compliance in TELS. Any concerns identified will be addressed immediately and the administrator notified.<br>4. This will be monitored for continued compliance by the Administrator and/or the Regional Director of Plant Operations and opportunities identified reported to the QAPI committee. | 08/18/2022 |

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| | Findings include:<br><br>Based on record review on 07/26/22 between 12:45 p.m. and 3:45 p.m. with the Maintenance Director present, there was no documentation on the generator monthly load test log for a 5 minute cool down time for the past 12 months. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the generator monthly load test log for a 5 minute cool down time.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference. | | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 07/26/22<br><br>Facility Number: 001144<br>Provider Number: 155668<br>AIM Number: 200256980<br><br>At this Life Safety Code survey, Diversicare of Providence was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. | K 0000 | Allegation of Compliance<br><br>Please accept the following plan of correction for the annual survey completed on July 26, 2022.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in | |

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| | This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, plus hard wired smoke detectors with battery back up in all resident sleeping rooms and several staff offices connected to a panel at the Nurses' Station (not the main fire alarm control panel). The facility has a total capacity of 172 with 158 certified beds and had a census of 131 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living area.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.<br><br>Quality Review completed on 07/26/22 | | continuing to better the quality of care provided to the residents in our community.<br><br>We respectfully request consideration for a desk review and paper compliance. | |
| K 0300<br>SS=F<br>Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on record review and interview, the facility failed to ensure documentation was available to show that all resident room and several staff offices smoke detectors were sensitivity tested within the past 24 months. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if | K 0300 | 1. 1. The smoke detector sensitivity test has been scheduled to be completed by Cintas on 8/17/2022.<br>2. 2. All residents of the Center have the potential to be affected.<br>3. 3. The administrator re-educated the maintenance director regarding the required | 08/18/2022 |

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| | sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:<br>(1) Calibrated test method.<br>(2) Manufacturer's calibrated sensitivity test instrument.<br>(3) Listed control equipment arranged for the purpose.<br>(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.<br>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.<br>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.<br>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on record review on 07/26/22 between 12:45 p.m. and 4:00 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all resident room and several staff offices smoke detectors for the past 24 month period. Based on observations | | smoke detector sensitivity test frequency to ensure compliance. This PM inspection has been added to TELS to recur every two years or as required.<br>4. 4. The maintenance director will oversee inspections to validate proper testing and supportive documentation, date of inspection, name of inspector and deficiencies discovered. | |

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| | between 10:15 a.m. and 12:45 p.m. during a tour of the facility with the Maintenance Director, it was determined smoke detectors in all resident rooms and several staff offices are hard wired to a panel at the Nurses' Station with battery back up. These smoke detectors are not connected to the fire alarm system but to a separate panel at the Nurses' Station to notify staff if activated. The Maintenance Director removed a resident room smoke detector and there was information on the back of the detector to show a sensitivity range. Based on interview at the time of observation, the Maintenance Director confirmed the detector removed from the resident room had a sensitivity range and acknowledged there was no record available for sensitivity testing for other smoke detectors of this type.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source | | | |

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| | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 14 smoke compartments covered with paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 resident, as well as staff and visitors within the smoke compartments.<br><br>Findings include:<br><br>Based on observations on 07/26/22 between 10:15 a.m. and 12:45 p.m. during a tour of the facility with the Maintenance Director, the following was noted:<br>a. There was one sprinkler head in the Ice Cream Parlor partially covered with paint.<br>b. There was one sprinkler head in resident room 118 partially covered with paint.<br>c. There was one sprinkler head in resident room 307 partially covered with paint.<br>Based on interview at the time of each observation, the Maintenance Director agreed the previously mentioned sprinkler heads in the Ice Cream Parlor and resident rooms 118 and 307 were partially covered with paint and should be replaced. | K 0353 | 1. 1. New sprinkler heads were ordered Brown Sprinkler Co. to replace the heads that were identified during the survey with paint on them. The heads will be replaced as soon as they have been delivered.<br>2. 2. All residents of the Center have the potential to be affected and a facility audit was completed to ensure there were no other sprinkler heads needing to be corrected or replaced.<br>3. 3. The maintenance director was educated by the administrator and will validate that sprinkler heads do not show signs of leakage, corrosion, foreign materials, paint or physical damage.<br>4. 4. Monthly rounds will be completed by maintenance to provide visual inspection of sprinkler heads to validate that sprinkler heads do not show signs of leakage, corrosion, foreign materials, paint or physical damage. Any areas noted will be corrected immediately. | 08/18/2022 |

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| | This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 2 of 2 sets of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect more than 50 residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on observations on 07/26/22 between 10:15 a.m. and 12:45 p.m. during a tour of the facility with the Maintenance Director, the following was noted: | K 0374 | 1. The maintenance director installed the door coordinators and ensured that they are functioning correctly.<br>2. All residents of the Center have the potential to be affected.<br>3. The maintenance director was educated by the administrator and will validate that smoke barrier doors have proper coordinators installed and function correctly.<br>4. Monthly rounds will be completed by maintenance to validate that smoke barrier doors have proper coordinators installed | 08/18/2022 |

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| | a. The set of smoke barrier doors between The Center and the Adult Day Care hall closed in the same direction with an astragal attached to one of the doors. There was no door coordinator attached to the door frame. There were two holes that had been filled in at the top of the door frame that appeared to have been where a coordinator was previously located.<br>b. The set of smoke barrier doors between The Center and the 300 hall closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the top of the door frame, however, it was placed only over one of the doors and was missing the roller. It did not work properly as a coordinator when tested.<br>Based on interview at the time of each observation, the Maintenance Director agreed the coordinator or lack of a coordinator did not allow the sets of smoke barrier doors to function as designed.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference.<br><br>3.1-19(b) | | and function correctly. Any areas noted will be corrected immediately. | |
| K 0918<br>SS=C<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer | | | |

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|---|---|
| DIVERSICARE OF PROVIDENCE | 4915 CHARLESTOWN RD<br>NEW ALBANY, IN 47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
|---|---|---|---|---|
| | switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) | | | |
| | Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 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. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine | K 0918 | 1. The emergency generator load test log includes a 5 minute cool down time, last generator load test completed on 8/5/2022.<br>2. All residents of the Center have the potential to be affected.<br>3. The maintenance director was educated by the administrator on completing the monthly load test logs and maintaining compliance in TELS. Any concerns identified will be addressed immediately and the administrator notified. | 08/18/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155668 | A. BUILDING 01<br>B. WING | 07/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| DIVERSICARE OF PROVIDENCE | 4915 CHARLESTOWN RD<br>NEW ALBANY, IN 47150 |

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| | 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, staff and visitors.<br><br>Findings include:<br><br>Based on record review on 07/26/22 between 12:45 p.m. and 3:45 p.m. with the Maintenance Director present, there was no documentation on the generator monthly load test log for a 5 minute cool down time for the past 12 months. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the generator monthly load test log for a 5 minute cool down time.<br><br>This finding was reviewed with the Administrator and Maintenance Director during the exit conference. | | 4. This will be monitored for continued compliance by the Administrator and/or the Regional Director of Plant Operations and opportunities identified reported to the QAPI committee. | |