

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2023

FORM APPROVED

OMB NO. 0938-039

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|--|---|---|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155696 | | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____ | | X3) DATE SURVEY COMPLETED 12/19/2022 | |
| NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 |
| E 0000 Bldg. -- | <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 12/19/22</p> <p>Facility Number: 003237 Provider Number: 155696 AIM Number: 200374360</p> <p>At this Emergency Preparedness survey, Bridgepointe Health Campus was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 75 certified beds. At the time of the survey, the census was 67.</p> <p>Quality Review completed on 12/22/22</p> | | | E 0000 | <p>The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally necessary services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during our Annual Life Safety Survey and Emergency Preparedness Survey conducted on December 19, 2023. The facility respectfully requests from the department a desk review for substantial</p> | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Michelle Weber

Executive Director

01/06/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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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| E 0039 SS=C Bldg. -- | <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may</p> | | | | compliance. | | |

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| | <p>include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> | | | | | | |

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| | <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared</p> | | | | | | |

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| | <p>questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> | | | | | | |

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| | <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and</p> | | | | | | |

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| | <p>maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's</p> | | | | | | |

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| | <p>emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d): (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct</p> | | | | | | |

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| | <p>exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The</p> | | | | | | |

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| | <p>OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the</p> | | | E 0039 | <p>The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations</p> | | 12/23/2022 |

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| | <p>following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 12/19/22 at 11:55 a.m. with the Executive Director and Director of Plant Operations, the emergency preparedness book entitled "Emergency Preparedness Plan" that was last reviewed on 02/25/22: a second full-scale exercise that is community-based or a second</p> | | | | <p>contained herein are an accurate, true representation of the quality of care or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally necessary services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during our Annual Life Safety Survey and Emergency Preparedness Survey conducted on December 19, 2023. The facility respectfully requests from the department a desk review for substantial compliance.</p> <p>Plan of Correction: E 039 Emergency Preparedness Completion Date: 12/23/22 1. Executive Director held a facilitator led tabletop disaster drill on 12/23/22 to reach</p> | | |

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| K 0000 Bldg. 01 | <p>individual, facility-based functional exercise, a mock disaster drill, a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan was not available for review. Based on an interview at the time of record review, the Executive Director confirmed that documentation for a second exercise of choice was not available for review at the time of this survey.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Facility Management Support.</p> <p>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).</p> <p>Survey Date: 12/19/22</p> <p>Facility Number: 003237 Provider Number: 155696 AIM Number: 200374360</p> <p>At this Life Safety Code survey, Bridgepointe Health Campus 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.</p> | | | K 0000 | <p>immediate compliance.</p> <p>2. Executive Director/DPO educated on the Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers.</p> <p>3. As a measure of ongoing compliance and as a quality measure, the ED/DPO will review at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings to maintain 100% compliance. The plan will be reviewed and updated as warranted.</p> <p>The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally necessary services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation</p> | | |

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| K 0222 SS=E Bldg. 01 | <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 75 and had a census of 67 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 12/22/22</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,</p> | | | | <p>for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during our Annual Life Safety Survey and Emergency Preparedness Survey conducted on December 19, 2023. The facility respectfully requests from the department a desk review for substantial compliance.</p> | | |

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| | <p>19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected</p> | | | | | | |

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| | <p>throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 1 of 7 exits. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 10 residents, staff, and visitors within the facility.</p> <p>Findings include:</p> <p>Based on observation on 12/19/22 at 12:25 p.m. with the Director of Plant Operations, Facility Management Support and Executive Director during a tour of the facility, when the 15 second delayed egress exit door was pushed in the Service Hall across from the kitchen; the irreversible process to release the lock was not initiated. This was confirmed by the Director of Plant Operations at the time of observation. The delayed egress door opened after inputting the</p> | | | K 0222 | <p>K 222 Egress Doors Completion Date: 1/5/23</p> <p>1. This deficient practice had the potential to affect 67 residents, staff, and visitors at the time of the survey.</p> <p>2. No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice.</p> <p>3. The Executive Director and/or designee provided re-education to the Director of Plant Operations on ensuring the delayed egress locking arrangements are installed in accordance with 7/2/1/6/1(3) and working properly with a 15 second egress.</p> <p>4. Stanley Healthcare performed maintenance of the back service hall door on 1/5/23 and within compliance. The Director of Plant Operations developed a weekly door inspection audit that includes monitoring the 15 second egress. The Director of Plant Operations and/or Designee will perform the observation audits 3/weekly, for 3 months. Findings will be reviewed during the quarterly QA committee to</p> | | 01/05/2023 |

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| K 0353 SS=F Bldg. 01 | <p>code on the keypad. Based on interview at the time of observation, the Director of Plant Operations agreed the exit door was not operating as designed and need to ensure the irreversible process to release the magnetic lock on the door works properly.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Facility Management Support at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and</p> | | | K 0353 | <p>determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in the cessation of the monitoring plan based on review.</p> <p>K 353 Sprinkler System-Maintenance and Testing Completion Date: 1/1/23 1. The deficient practice had the potential to affect 67 resident,</p> | | 01/01/2023 |

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| K 0521 SS=F Bldg. 01 | <p>Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Director of Plant Operations on 12/19/22 between 10:13 a.m. and 11:56 a.m., there were no monthly inspections of the wet pipe sprinkler system's gauges and valves prior to April 2022. Based on interview at the time of record review, the Director of Plant Operations stated he had been at the facility for about seven months, and the documentation provided is all that is available for review at the time of the survey.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations and Facility Management Support at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> | | | | <p>staff, and visitors, with no findings.</p> <p>2. Director of Plant Operations was trained to inspect the sprinkler gauges and valves monthly.</p> <p>3. Director of Plant Operations and/or designee will check the sprinkler gauges and valves 1x/week with documentation of the weekly checks on a log sheet that will be placed in our TELS system for monitoring.</p> <p>4. Findings will be reviewed during our quarterly QA committee to monitor/maintain 100% compliance.</p> | | |

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| | <p>Based on record review and interview, the facility failed to ensure all fire and smoke dampers in the facility were inspected and provided necessary maintenance at least every four 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 then 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. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 12/19/22 at 11:13 a.m., the most recent fire / smoke damper testing document provided for review was dated 10/05/18. The lack of current four-year maintenance conducted on the fire / smoke dampers was confirmed by the Director of Plant Operations at the time of record review who stated that he would get the damper</p> | | | K 0521 | <p>K 521 NFPA 101 HVAC/Fire Dampers Completion Date: 1/13/23</p> <ol style="list-style-type: none"> The deficient practice had the potential to affect 67 resident, staff, and visitors, with no findings. Director of Plant Operations was educated by the Executive Director on the NFPA 101 HVAC related to inspection of all fire and smoke dampers in the facility per the four-year maintenance requirement. Director of Plant Operations has started the inspection of all dampers with a completion date of 1/13/23. | | 01/13/2023 |

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| K 0918 SS=C Bldg. 01 | <p>inspection and testing done.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Facility Management Support at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing 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 switches are performed in accordance with NFPA 110. 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,</p> | | | | | | |

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| | <p>and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 13 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 12/19/22 from 10:13 a.m. to 11:55 a.m., documentation for weekly generator testing was not available for review for 13 weeks prior to 03/29/22. Based on an interview at the time of record review, the Director of Plant Operations stated he has been at the facility for seven months and no other weekly generator testing documentation was available for review at the time of the survey.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Facility Management Support at the exit conference.</p> | | | K 0918 | <p>K 918 Generator Completion Date: 1/1/23</p> <p>1. The deficient practice had the potential to affect 67 residents, staff, and visitors with no findings.</p> <p>2. Director of Plant Operations was educated by the Facility Manager Support and Executive Director on the completion of exercising the generator including running the generator under load for 30 minutes with a 5-minute cool down weekly.</p> <p>3. Director of Plant Operations is currently in compliance with running the generator under load for 30 minutes with a 5-minute cool down to maintain compliance by auditing weekly. QA committee to monitor/maintain 100% compliance and if findings suggestive may result in the cessation of monitoring plan based upon review.</p> | | 01/01/2023 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155696 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | | X3) DATE SURVEY COMPLETED 12/19/2022 | |
| NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS | | | | STREET ADDRESS, CITY, STATE, ZIP COD 1900 COLLEGE AVE VINCENNES, IN 47591 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | 3.1-19(b) | | | | | | |