STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING -- B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/19/19 Facility Number: 000247 Provider Number: 155356 AIM Number: N/A At this Emergency Preparedness survey, Transitional Care Unit of St Joseph was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 20 certified beds. At the time of the survey, the census was 14. Quality Review completed on 02/20/19 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This Facility is requesting Paper Compliance.	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident	E 0015	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Policies addressing alternate sources of energy, emergency lighting, and temperatures to	03/21/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING -- B. WING	02/19/2019

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

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	health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director, Administrator and Quality Director on 02/19/19 at 10:35 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for temperatures to protect resident health and safety, alternate sources of energy and emergency lighting was not available for review. Based on interview at the time of record review, the Maintenance Director, Administrator and Quality Director stated the facility has plans for the aforementioned programs but could not be located.		protect resident health and safety will be developed and implemented by the Emergency Manager before March 21 2019. The Policies and Procedures will be in compliance with Life Safety Regulations and will address the following: 1.Food, water, medical and pharmaceutical supplies – Please see attached EM 02.02.16 Shelter in Place Policy 2.Alternate sources of energy to maintain the following: 1.Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. Please see attached EM 02.02.19 Care in Extreme Temperatures Policy 2.Emergency Lighting. Please see attached EM 02.02.17 and EM 02.02.18 Lighting Disruption and Alternate Energy Plan Policies 3.Fire detection, extinguishing and alarm systems. Please see attached EC 02.03.05.15-16 Portable Fire Extinguisher Policy 4.Sewage and waste disposal. Please see attached EM 02.02.20 Disruption of Plumbing System <u>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155356	A. BUILDING -- B. WING	02/19/2019

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

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			This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I. Policies addressing alternate sources of energy, emergency lighting, and temperatures to protect resident health and safety will be developed and implemented by the Emergency Manager before March 21 2019. The Policies and Procedures will be in compliance with Life Safety Regulations and will address the following: 1.Food, water, medical and pharmaceutical supplies – Please see attached EM 02.02.16 Shelter in Place Policy 2.Alternate sources of energy to maintain the following: 1.Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. Please see attached EM 02.02.19 Care in Extreme Temperatures Policy 2.Emergency Lighting. Please see attached EM 02.02.17 and EM 02.02.18 Lighting Disruption and Alternate Energy Plan Policies 3.Fire detection, extinguishing and alarm systems. Please see attached EC 02.03.05.15-16 Portable Fire Extinguisher Policy 4.Sewage and waste disposal. Please see attached EM 02.02.20 Disruption of Plumbing System	

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			III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·The aforementioned Policies will be reviewed once a year by Facilities Director, Emergency Manager and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. ·The Polices will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. ·All staff on TCU will be educated on these policies before March 21 2019. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** ·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will be accomplished by March 21 2019. This will include Policy review once a year by Facilities Director, Emergency Manager and	

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			Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. The Policies will also be reviewed by the QAPI team members once a year. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2018	
E 0020 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director, Administrator and Quality Director on 02/19/19 at 11:35 a.m., the provided policy and procedures documentation which included information for safe evacuation from the LTC facility did not include transportation procedures the facility would use during an evacuation. Based on interview at the time of record review, the Quality Director stated the facility does have agreements for provided transportation but there	E 0020	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Emergency Evacuation Policy and Procedure will include information for safe evacuation from the Transitional Care Unit which includes transportation procedures that the facility would use during evacuation. It will also include consideration of care and treatment needs of evacuees, staff responsibilities, identification of evacuation location ; and primary and alternate means of communication with external sources of assistance. This will be completed and implemented by the Emergency Manager before March 21 2019. Please see Policy EM.02.02.11.3 Evacuation Plan (Resources and Equipment for	03/21/2019

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

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	was no written procedures for emergency transportation during evacuation.		Evacuation of Patients including Transportation) <u>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</u> This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I. The Emergency Evacuation Policy and Procedure will include information for safe evacuation from the Transitional Care Unit which includes transportation procedures that the facility would use during evacuation. It will also include consideration of care and treatment needs of evacuees, staff responsibilities, identification of evacuation location ; and primary and alternate means of communication with external sources of assistance. This will be completed and implemented by the Emergency Manager before March 21 2019. Please see Policy EM.02.02.11.3 Evacuation Plan (Resources and Equipment for Evacuation of Patients including Transportation) **<u>III. What measures will be put</u>**	

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			into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·All staff on TCU will be educated on the Emergency Evacuation Policy and Procedure before March 21 2019. ·The Policy and Procedure will be reviewed once a year by Facilities Director, Emergency Manager and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. ·The Polices will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** ·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will be accomplished by March 21 2019. This will include Policy review once a year by Facilities Director, Emergency Manager and	

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			Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. The Policies will also be reviewed by the QAPI team members once a year. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2019	
E 0022 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director, Administrator and Quality Director on 02/19/19 at 11:25 a.m., a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility was not available for review. Based on interview at the time of record review, the Quality Director confirmed a shelter in place policy and procedure was not available to review.	E 0022	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Emergency Preparedness Policy addressing Shelter in Place for residents, staff and volunteers will be developed and implemented by the Emergency Manager before March 21 2019. Please see attached EM.02.02.16 Shelter in Place Policy II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken This has the potential to affect all residents equally. Therefore, the	03/21/2019

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			Plan will be the same as outlined in I. Emergency Preparedness Policy addressing Shelter in Place for residents, staff and volunteers will be developed and implemented by the Emergency Manager before March 21 2019. Please see attached EM.02.02.16 Shelter in Place Policy **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** ·All staff on TCU will be educated on the Shelter in Place Policy and Procedure before March 21 2019. ·The Policy and Procedure will be reviewed once a year by Facilities Director, Emergency Manager and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. ·The Policy will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. **IV. How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; ·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will be accomplished by March 21 2019. This will include Policy review once a year by Facilities Director, Emergency Manager and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. The Policy will also be reviewed by the QAPI team members once a year. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2019	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/19/19 Facility Number: 000247 Provider Number: 155356 AIM Number: N/A	K 0000	This Facility is requesting Paper Compliance.	

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	At this Life Safety Code survey, Transitional Care Unit of St. Joseph was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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. The facility has elected to utilize a Categorical Waiver pertaining to electric motor driven fire pump assemblies and is in compliance. The Transitional Care Unit was fully sprinklered and located on the ninth floor of an ten story partially sprinklered hospital of Type I (332) construction. The facility has a fire alarm system with smoke detection in the areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 20 and had a census of 14 at the time of this survey. Quality Review completed on 02/20/19			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire	K 0346	I. What corrective action(s) will be accomplished for those residents found to have been affected by	03/21/2019

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	alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 02/19/19 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		the deficient practice; The Facilities Director will ensure that the Fire Watch Plan includes how to contact the ISDH should the Fire Watch Plan be executed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period accordance with LSC, Section 9.6.1.6 The fire watch plan will include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov . Please see attached LS.01.02.01.2 Fire watch Policy. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I.	

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			The Facilities Director will ensure that the Fire Watch Plan includes how to contact the ISDH should the Fire Watch Plan be executed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period accordance with LSC, Section 9.6.1.6 The fire watch plan will include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov . Please see attached LS.01.02.01.2 Fire watch Policy. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** ·The Facilities, Security and Transitional Care Unit Leadership Staff will be educated on this process and their role in the event that a Fire Watch Plan needs executed. ·The Fire Watch Plan will be reviewed once a year by Facilities Director and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard.	

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			·The Fire Watch Plan will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** ·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will be accomplished by March 21 2019. This will include Fire watch Plan review once a year by Facilities Director and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. The Policy will also be reviewed by the QAPI team members once a year. ·This will be added in our QAPI Plan before March 21 2019. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2018	

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TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

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K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the	K 0354	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Facilities Director will ensure that the Fire Watch Plan includes how to contact the ISDH should the Fire Watch Plan be executed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period accordance with LSC, Section 9.6.1.6 The fire watch plan will include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the	03/21/2019

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	facility. Findings include: Based on records review with the Maintenance Director and Administrator on 02/19/19 at 9:35 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov . Please see attached LS.01.02.01.2 Fire Watch Policy. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I The Facilities Director will ensure that the Fire Watch Plan includes how to contact the ISDH should the Fire Watch Plan be executed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period accordance with LSC, Section 9.6.1.6 The fire watch plan will include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting	

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			form and emailing it to incidents@isdh.in.gov . Please see attached LS.01.02.01.2 Fire Watch Policy. III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·The Facilities, Security and Transitional Care Unit Leadership Staff will be educated on this process and their role in the event that a Fire Watch Plan needs executed. ·The Fire Watch Plan will be reviewed once a year by Facilities Director and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. ·The Fire Watch Plan will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is me **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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			·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will be accomplished by March 21 2019. This will include Fire watch Plan review once a year by Facilities Director and Administrator to ensure that any changes are reviewed and updated to ensure compliance with this standard. The Policy will also be reviewed by the QAPI team members once a year. ·This will be added in our QAPI Plan before March 21 2019. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2018	
K 0532 SS=F Bldg. 01	NFPA 101 Escalators, Dumbwaiters, and Moving Walks Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.			

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	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 Based on records review and interview the facility failed to ensure 7 of 7 elevators had current State of Indiana inspection documentation. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 02/19/19 at 12:35 p.m., the provided State of Indiana elevator annual inspection documentation for elevators 1, 2, 3, 4, and 9 had an expiration date of 9/15/18, elevator 11 had a expiration date of 7/10/18, and elevator 10 had a expiration date 02/26/18. Based on interview at the time of records review, the Maintenance Director acknowledged current elevator inspection documentation were out of date and stated the facility is waiting on the state inspector to conduct the inspections. 3.1-19(b)	K 0532	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Facilities Director or designee will ensure that the elevator inspection of all 7 elevators are scheduled and inspections and documentation completed and available before March 21 2019. Please see the attached Elevator Inspection certificates that demonstrate completion of the inspections and documentation. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I.	03/21/2019

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			The Facilities Director or designee will ensure that the elevator inspection of all 7 elevators are scheduled and inspections and documentation completed and available before March 21 2019. Please see the attached Elevator Inspection certificates that demonstrate completion of the inspections and documentation. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** ·The Elevator Inspection Documentation will be reviewed once a year by Facilities Director and Administrator to ensure that all the elevators are inspected and the State of Indiana inspection documentation is completed and available to ensure compliance with this standard. ·The Elevator Inspection documentation will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place; ·The corrective action Plan will be added and monitored via the TCU QAPI (Quality Assurance Performance improvement) Program. This will include review of the Elevator Inspection Documentation once a year by Facilities Director and Administrator to ensure that all the elevators are inspected by the State of Indiana. This will also be reviewed by the QAPI team members once a year. ·This will be added in our QAPI Plan before March 21 2019. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2018	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3,			

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	19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: A) Based on records review with the Maintenance Director and Administrator on 02/19/19 at 10:45 a.m., the provided fire safety plan did not include the emergency phone call to fire department. Based on an interview during records review, the Maintenance Director and Administrator looked through the fire safety plan and stated the emergency phone call to the fire department was not in the fire plan. B) Based on records review with the Maintenance Director and Administrator on 02/19/19 at 10:55 a.m., the facility's fire safety plan did explain how to use a fire extinguisher but did not explain what types of fire extinguishers are in the facility and what each extinguishers is used for. According to the fire extinguisher inspection paper work there are four type of extinguishers in the facility, which include ABC, K Class, Halotron, and CO2. Based	K 0711	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Facilities Director or designee will ensure that the Fire Response Plan includes the Emergency Phone Call made to the Fire Department in case of a Fire. The Portable Fire Extinguisher Policy will also include and specify the type of Fire Extinguisher that is used in the Facility (ABC). This will be completed before March 21 2019. Please see attached EC.02.03.01.9-10 Fire Response Plan and EC.02.03.05.15-16 Portable Fire Extinguisher Policy II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This has the potential to affect all residents equally. Therefore, the Plan will be the same as outlined in I. The Facilities Director or designee will ensure that the Fire Plan includes the Emergency Phone Call made to the Fire Department in case of a Fire. The Fire Plan will	03/21/2019

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	on interview at the time of records review, the Maintenance Director and Administrator looked through the plan and stated there was no information on what type of fire extinguishers are in the facility. 3.1-19(b)		also include and specify the type of Fire Extinguisher that is used in the Facility (ABC). This will be completed before March 21 2019. Please see attached EC.02.03.01.9-10 Fire Response Plan and EC.02.03.05.15-16 Portable Fire Extinguisher Policy **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** ·The Security Staff who will be responsible to call the Fire Department will be educated in this policy and all new hires in the Security Department will also be educated ·The Fire Plan will be reviewed once a year by Facilities Director and Administrator to ensure that all the components of the Fire Plan including calling the Fire Department and documentation of the type of extinguisher used on TCU is included to ensure compliance with this standard. ·The above information will also be reviewed once a year in October at the QAPI (Quality Assurance Performance Improvement) meeting and will be reviewed by the team members to ensure that the standard is met. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place ·The corrective action Plan outlined above will be added and monitored by the TCU QAPI (Quality Assurance Performance improvement) Program. This will include review of the documentation related to Phone Call being made to the Fire Department in case of a Fire. In addition, the QAPI members will ensure the specific type of Fire Extinguisher that is used in the Facility (ABC) is documented in the Fire Plan. ·This will be added in our QAPI Plan before March 21 2019. **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 21 2018	