| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155720 | A. BUILDING -- B. WING | 09/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CATHEDRAL HEALTH CARE CENTER | 520 W 9TH ST JASPER, IN 47546 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 09/24/2024<br><br>Facility Number: 000315<br>Provider Number: 155720<br>AIM Number: 100289030<br><br>At this Emergency Preparedness survey, Cathedral Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has a capacity of 65 certified beds and had a census of 63 at the time of this visit.<br><br>Quality Review completed on 09/26/24 | E 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 11th, 2024 to the survey completed on September 24th, 2024. We respectfully request a paper review and will provide any additional information requested. | |
| 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: 09/24/2024<br><br>Facility Number: 000315<br>Provider Number: 155720<br>AIM Number: 100289030<br><br>At this Life Safety Code survey, Cathedral Health | K 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 11th, | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Allision Betz | HFA | 10/04/2024 |

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| | Care Center 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.<br><br>This two story facility with a basement was determined to be of Type II (222) 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 65 and had a census of 63 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a generator building, and a greenhouse.<br><br>Quality Review completed on 09/26/24 | | 2024 to the survey completed on September 24th, 2024. We respectfully request a paper review and will provide any additional information requested. | |
| K 0200 SS=E Bldg. 01 | NFPA 101<br>Means of Egress Requirements - Other<br><br>Based on observation and interview, the facility failed to ensure 1 of 1 bathroom shared between the social services office and activities office, 1 of 1 bathroom shared between the MDS office and the ADON office, and 1 of 1 bathroom shared between the sensory room and exam room which were able to be unlocked from both the inside and outside in case of fire or other emergencies were readily accessible in accordance with LSC 7.1.10.1. This deficient practice could affect at least 6 staff, residents, and visitors occupying the bathrooms.<br><br>Findings include: | K 0200 | **K 200**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**<br><br>No residents, staff, or visitors were found to be affected by the deficient practice.<br><br>**How other residents that have the potential to be affected by the same defective practice** | 10/11/2024 |

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| | Based on observations on 09/24/2024 between 11:00 AM and 1:00 PM with the Administrator-in-Training and the Environmental Services Director, the following was observed:<br>a. The bathroom shared between the social services office and the activities office had slide locks on the inside of both of the bathroom doors. Each office has their own door to the bathroom.<br>b. The bathroom shared between the MDS office and ADON office had a slide lock on the outside of both of the bathroom doors. Each office has their own door to the bathroom.<br>c. The bathroom shared between the sensory room and exam room had a slide lock on the inside of the bathroom door on the exam room side, a key padlock on the inside of the bathroom door on the sensory room side, and a slide lock on the outside of the door on the sensory room side. The sensory room and the exam room have their own door to the shared bathroom.<br>Based on interview at the time of observation, the Environmental Services Director agreed there were locks on the doors in the aforementioned locations which did not allow for the doors to be unlocked from both sides of the doors in the event of an emergency.<br><br>This finding was reviewed with the Environmental Services Director, Administrator-in-Training, and Administrator at the exit conference.<br><br>3.1-19(b) | | **will be identified and what corrective action(s) will be taken:**<br><br>Potentially all residents, staff, and visitors could be affected but none were identified.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Identified locks removed on doors.<br><br>**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:**<br><br>An audit will be completed by maintenance or designee on all the second-floor office hallway Manager shared bathroom doors weekly, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.<br><br>**The date the systemic changes will be completed:** | |

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| | | | October 11th, 2024 | |
| K 0321 SS=E Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchen was provided with a properly working self closing device, and was not impeded from closing.<br><br>Findings include:<br><br>Based on observations during a tour of the facility on 09/24/2024 between 11:00 AM and 1:00 PM with the Environmental Services Director and the Administrator-in-Training, the kitchen door to the dining room was equipped with a self-closing device, but was being kept open with a bungee cord. Based on interview at the time of observation, the Environmental Services Director agreed the door was being held open with a bungee cord. This condition was corrected by the Environmental Services Director at the time of observation. Staff voiced concern regarding having to open the door each time they needed to go through the door when serving meals.<br><br>This finding was reviewed with the Environmental Services Director, Administrator-in-Training, and Administrator at the exit conference.<br><br>3.1-19(b) | K 0321 | **K 321**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**<br><br>No residents were found to be affected by the deficient practice.<br><br>**How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:**<br><br>Potentially staff and residents could be affected but none were identified.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Deficient practice was corrected immediately. Checks on main kitchen door weekly.<br><br>**How the corrective action(s) will be monitored to ensure the** | 10/11/2024 |

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| | | | **deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>An audit will be completed by maintenance or designee on the main kitchen door weekly, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.<br><br>**The date the systemic changes will be completed:**<br><br>October 11th, 2024 | |
| K 0345<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observation of the fire alarm control panel on 09/24/2024 at 12:14 PM with the Environmental Services Director and | K 0345 | **K 345**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**<br><br>No staff, visitors, or residents were found to be affected by the deficient practice.<br><br>**How other residents that have the potential to be affected by the same defective practice will be identified and what** | 10/11/2024 |

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| | Administrator in Training, the fire alarm control panel indicated the date was 05/08/2015 at 7:29. The fire panel did not indicate if the time was AM or PM. The Environmental Services Director was able to update the date and time to the correct date and time. Based on interview at the time of the observation, the Environmental Services Director stated the vendor had not corrected the time and date when they had changed the battery on the fire panel.<br><br>This finding was reviewed with the Administrator, Administrator-in-Training, and Environmental Services Director at the exit conference.<br><br>3.1-19(b) | | **corrective action(s) will be taken:**<br><br>Potentially staff, visitors, and residents could be affected but none were identified.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Deficient practice was immediately corrected. Fire panel will be inspected monthly to ensure compliance.<br><br>**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:**<br><br>An audit will be completed by maintenance or designee of the Fire Panel date and time monthly in conjunction with monthly fire drills, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.<br><br>**The date the systemic changes will be completed:** | |

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| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 basement janitor's closet, 1 of 1 auditorium, and 1 of 1 PPE closet, all on the basement level. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff.<br><br>Findings include:<br><br>Based on observation during a tour of the facility on 09/24/2024 between 11:00 AM and 1:00 PM with the Administrator-in-Training and Environmental Services Director, the janitor's closet in the basement was observed to have a 3 inch by 6 inch penetration in the ceiling around 2 pipes to the left of the door, a 2 inch by 2 inch penetration in the ceiling around the pipe in the corner to the right of the door, and a 0.5 inch penetration in the ceiling around the pipe above the sink to the right of the door. The auditorium in the basement was observed to have a penetration in the ceiling by the northwest corner of the room of 2 inch by 2 inch. The PPE closet in the basement was observed to have a penetration | K 0353 | **K 353**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**<br><br>No residents, staff, or visitors were found to be affected by the deficient practice.<br><br>**How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:**<br><br>Potentially all residents, staff, and visitors could be affected but none were identified.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Fire caulking placed in deficient area identified. Monthly checks initiated to ensure compliance.<br><br>**How the corrective action(s)** | 10/11/2024 |

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| | in the ceiling of 4 inch by 6 inch surrounding a black pipe and a white pipe. In this same location, a penetration of 2 inches was located around a silver pipe. Based on interview at the time of observation, the Environmental Services Director agreed there were penetrations in the ceiling in the aforementioned locations and provided the measurements.<br><br>This finding was reviewed with the Environmental Services Director, Administrator-in-Training, and Administrator at the exit conference.<br><br>3.1-19(b) | | **will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>An audit will be completed by maintenance director or designee monthly for ceiling penetrations, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.<br><br>**The date the systemic changes will be completed:**<br><br>October 11th, 2024 | |
| K 0372<br>SS=E<br>Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Based on observation and interview, the facility failed to ensure the penetrations through 1 of 1 smoke barrier wall near the Pepsi vending machine on the 1st floor was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff, 20 residents, and visitors in this smoke compartment.<br><br>Findings include: | K 0372 | **K 372**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**<br><br>No residents, staff, or visitors were found to be affected by the deficient practice.<br><br>**How other residents that have the potential to be affected by the same defective practice** | 10/11/2024 |

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| | Based on observation during a tour of the facility on 09/24/2024 between 11:00 AM and 1:00 PM with the Administrator-in-Training and Environmental Services Director, the barrier wall near the Pepsi vending machine on the first floor was observed to have 1 penetration of 0.5 inch around 4 wires. Based on interview at the time of observation, the Environmental Services Director agreed there was a penetration in the aforementioned location and provided the measurement.<br><br>This finding was reviewed with the Administrator-in-Training, Environmental Services Director, and Administrator at the exit conference.<br><br>3.1-19(b) | | **will be identified and what corrective action(s) will be taken:**<br><br>Potentially all residents, staff, and visitors could be affected but none were identified.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Fire caulking placed in area of deficient practice identified. Monthly checks of area initiated.<br><br>**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:**<br><br>An audit will be completed by maintenance director or designee monthly for smoke barrier wall penetrations, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.<br><br>**The date the systemic changes will be completed:** | |

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| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 1 of 1 business manager's office. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 3 staff.<br><br>Findings include:<br><br>Based on observations on 09/24/2024 between 11:00 AM and 1:00 PM with the Environmental Services Director and Administrator-in-Training, a mini fridge was plugged into a power strip in the business manager's office. Staff corrected this at the time of observation. Based on interview at the time of observation, the Environmental Services Director agreed the mini fridge was plugged into the power strip in the aforementioned location.<br><br>This finding was reviewed with the Administrator-in-Training, Environmental Services Director, and Administrator at the exit conference.<br><br>3.1-19(b) | K 0920 | **K 920**<br>**The corrective action taken for those residents found to be affected by the deficient practice include:**No staff were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:**Potentially staff could be affected by defective practice. None identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**Deficient practice was corrected immediately. Weekly checks initiated to ensure compliance.**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:**An audit will be completed by maintenance director or designee weekly to ensure power strips are not being used as a substitute for fixed wiring, and any future negative | 10/11/2024 |

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| | | | findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting.**The date the systemic changes will be completed:**October 11th, 2024 | |