

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154050	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2021
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NAME OF PROVIDER OR SUPPLIER NORTHEASTERN CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WESLEY RD AUBURN, IN 46706
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A 0000 Bldg. 00	<p>The visit was for a Federal Hospital re-certification survey and a focused Infection Control survey.</p> <p>Facility Number: 003734</p> <p>Survey Date: 1/19-21/21</p> <p>Northeastern Center was found in compliance with CMS Focused Infection Control Survey for Acute and Continuing Care.</p> <p>QA: 1/27/21 and 2/26/21</p>	A 0000		
A 0118 Bldg. 00	<p>482.13(a)(2) PATIENT RIGHTS: GRIEVANCES</p> <p>The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.</p> <p>Based on document review and interview, the facility failed to maintain its grievance process and to ensure an address for lodging a grievance directly with the State agency was provided to the patient and/or the patient's representative for one facility.</p> <p>Findings include:</p> <p>1. Review of the policy/procedure Consumer Grievances (reviewed 1-20) and review of the Patient Rights and Responsibilities handbook (revised 10-19) lacked documentation indicating the address for submitting a grievance with the Indiana Protection and Advocacy Service (IPAS) agency.</p>	A 0118	<p>NEC policy, along with Patient Rights and Responsibilities handbook, will be revised by QI Coordinator to include the mailing address for submitting a grievance in writing to the Indiana Protection and Advocacy Service (IPAS). QI Coordinator will be responsible for revising policy, linking A118 Standard to grievance policy in PowerDMS system, and monitor annually through policy review that the mailing address is included in both the policy and Rights and Responsibilities Booklet.</p>	04/30/2021

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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 disclosed days 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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A 0700 Bldg. 00	<p>3. On 1-21-21 at 1037 hours, the Quality Specialist A8 confirmed the above.</p> <p>482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.</p> <p>Based on record review, observation, and interview; the facility failed to ensure 15 of 15 fire dampers in the facility were inspected and provided necessary maintenance (see tag K522), failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2 (see tag K711), failed to ensure the hospital grade electrical receptacles in 16 of 16 patient sleeping rooms were tested at least annually (see tag K914) failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1 (see tag K918) and failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3 (see tag K918).</p> <p>The cumulative effect of this systemic problem resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure</p>	A 0700	<p>Facility will maintain an environment of care that ensures the safety of all patients.</p> <p>1. NEC has addressed periodic inspection all fire dampers (refer to K522). + NEC will inspect all fire dampers at least every 6 years per standard. Initial inspection was conducted 1/29/2021 and the next fire damper inspection will be completed by 1/29/2027. Maintenance Director will ensure that inspections occur. QI Coordinator and Nurse Manager will monitor that inspections have occurred.</p> <p>2. Fire safety plan is being revised to include identification of smoke barrier walls, instructions for evacuation of a smoke compartment, and requirement to call the fire department (refer to K711). + Smoke barrier walls will be identified on displayed exit maps. Maintenance Director and IP Director to ensure</p>	04/30/2021	

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	the provision of quality health care in a safe environment.		maps are implemented and posted. IP Director and HR Director will ensure IP staff are trained on fire control plan annually. QI coordinator will verify initial training occurs and that policy is reviewed annually and updated as needed. Nurse Manager (RM Nurse) will ensure NEC policy is revised to include: 1. a map identifying smoke barrier walls 2. instructions on how and when to evacuate a smoke compartment 3. requirement to make emergency call to fire department (even if the alarm system seems to be operational) 4. type of fire extinguisher available and how to use a fire extinguisher 3. Annual testing of electrical receptacles is being addressed (refer to K914). + NEC will perform an annual test of electrical receptacles in patient rooms, including tension pressure test and ground test. These items will be added to the annual facility maintenance checklist for IP for documentation. The initial tension pressure tests were completed on 2/24/2021 and the initial ground tests were completed on 3/26/2021. Maintenance Director will ensure that Annual Inspection of Facility policy and checklist are revised and the annual tests are performed per policy. QI Coordinator and Nurse Manager (RM Nurse) to verify that policy	

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A 0701 Bldg. 00	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are		changes were made and monitor for compliance annually. 4. Generator load exercise and fuel quality testing has been implemented (refer to 918). + Nurse Manager (RM Nurse) & QI Coordinator to monitor annually for compliance. + 1. NEC will test the generator with a 4 hour continuous run under load every 3 years at a minimum. The 4 hour run under load test will be added to the annual inspection checklist for IP, with dates to be noted. Initial load bank testing was completed on 3/3/2021. Maintenance Director will ensure that the policy and checklist are changed and load bank testing is conducted. + 2. NEC will conduct a diesel fuel quality test annually following ASTM standards. The diesel fuel quality test will be added to the annual inspection checklist policy for IP. The initial fuel quality test was completed on 3/3/2021. Maintenance Director will ensure fuel tests are run annually and that revisions to the policy are made to reflect requirements of the standard.	

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	<p>assured.</p> <p>#1. Based on observation, record review and interview, the facility failed to ensure the hospital grade electrical receptacles in 16 of 16 patient sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.1 states where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all patients in the facility. Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Coordinator and the Maintenance Forman on 01/21/21 between 11:00 a.m. and 1:00 p.m., the facility's 16 patient sleeping rooms contained four hospital grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show electrical receptacles in patient sleeping rooms were tested after initial installation, replacement, or servicing of the device. Based on interview at the time of the observation and records review, the Maintenance Forman confirmed all of the electrical receptacles in the patient sleeping rooms were</p>	A 0701	<p>Facility will maintain an environment of care that ensures the safety of all patients.</p> <p>1. Annual testing of electrical receptacles is being addressed (refer to K914). + NEC will perform an annual test of electrical receptacles in patient rooms, including tension pressure test and ground test. These items will be added to the annual facility maintenance checklist for IP for documentation. The initial tension pressure tests were completed on 2/24/2021 and the initial ground tests were completed on 3/26/2021. Maintenance Director will ensure that Annual Inspection of Facility policy and checklist are revised and the annual tests are performed per policy. QI Coordinator and Nurse Manager (RM Nurse) to verify that policy changes were made and monitor for compliance annually.</p> <p>2. & 3. Generator load exercise and fuel quality testing has been implemented (refer to 918). 2: + NEC will test the generator with a 4 hour continuous run under load every 3 years at a minimum. The 4 hour run under load test will be added to the annual inspection checklist for IP, with dates to be noted. Initial load bank testing was completed on 3/3/2021. Maintenance Director will ensure that the policy and</p>	04/30/2021	

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	<p>hospital-grade and stated testing per NFPA 99, Receptacle Testing requirements has not been completed.</p> <p>This finding was reviewed with the Maintenance Coordinator, the Maintenance Forman, and the Quality Improvement Assistant at the exit conference.</p> <p>#2. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>During records review with the Maintenance Coordinator and the Maintenance Forman on 01/21/21 at 11:14 a.m., documentation of a four-hour continuous run under load for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Forman stated a four-hour continuous run under load was not conducted in the past 36 months.</p> <p>#3. Based on record review and interview, the</p>		<p>checklist are changed and load bank testing is conducted.</p> <p>3: + NEC will conduct a diesel fuel quality test annually following ASTM standards. The diesel fuel quality test will be added to the annual inspection checklist policy for IP. The initial fuel quality test was completed on 3/3/2021. Maintenance Director will ensure fuel tests are run annually and that revisions to the policy are made to reflect requirements of the standard.</p> <p>Nurse Manager (RM Nurse) & QI Coordinator to monitor annually for compliance.</p>	

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A 0710 Bldg. 00	<p>facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>During records review with the Maintenance Coordinator and the Maintenance Forman on 01/21/21 at 11:19 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Forman stated the facility does have a diesel generator but was unaware of the fuel quality testing requirements and did not have the fuel tested.</p> <p>The findings were reviewed with the Maintenance Coordinator, the Maintenance Forman, and the Quality Improvement Assistant at the exit conference.</p> <p>482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (b) Standard: Life safety from fire. (1) Except as otherwise provided in this section—</p> <p>(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and</p>				

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	<p>Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.</p> <p>(ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.</p> <p>(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.</p> <p>Based on record review, observation, and interview; the facility failed to ensure 15 of 15 fire dampers in the facility were inspected and provided necessary maintenance. 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</p>	A 0710	<p>NEC has addressed periodic inspection all fire dampers (refer to K522).</p> <p>NEC will inspect all fire dampers at least every 6 years per standard. Initial inspection was conducted 1/29/2021 and the next fire damper inspection will be completed by 1/29/2027. Maintenance Director will ensure that inspections occur.</p>	01/29/2021	

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	<p>Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Coordinator and the Maintenance Forman on 01/21/21 between 11:00 a.m. and 1:00 p.m., there were smoke/fire dampers noted in the HVAC duct work throughout the building. Based on records review at 10:30 a.m., no documentation of an inspection for the smoke/fire dampers in the facility was available for review. Based on interview at the time of records review and observation, the Maintenance Forman stated there are about 15 smoke/fire dampers in the facility and no inspection has been conducted since the dampers were installed over six years ago.</p> <p>This finding was reviewed with the Maintenance Coordinator, the Maintenance Forman, and the Quality Improvement Assistant at the exit conference.</p>		<p>QI Coordinator and Nurse Manager will monitor that inspections have occurred.</p>	

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A 0714 Bldg. 00	<p>482.41(b)(5) FIRE CONTROL PLANS</p> <p>(5) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.</p> <p>Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms 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. <p>This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Quality Improvement Assistant on 01/21/21 at 1:17 p.m., the provided facility's fire safety plan did not address the following items:</p> <p>a) Extinguishment of fire. The fire safety plan did not indicate how use a fire extinguisher and did not address the types of fire extinguishers in the facility.</p> <p>b) Evacuation of smoke compartment. The facility did not address how to evacuate a smoke compartment nor identify the smoke barrier walls and smoke compartments in the facility.</p>	A 0714	<p>Fire safety plan is being revised to include identification of smoke barrier walls, instructions for evacuation of a smoke compartment, requirement to call the fire department, and use of fire extinguishers (refer to K711).</p> <p>+ Smoke barrier walls will be identified on displayed exit maps. Maintenance Director and IP Director to ensure maps are implemented and posted.</p> <p>+ NEC policy will be revised to include: 1. a map identifying smoke barrier walls 2. instructions on how and when to evacuate a smoke compartment 3. requirement to make emergency call to fire department (even if the alarm system seems to be operational) 4. type of fire extinguisher available and how to use a fire extinguisher</p> <p>+ Nurse Manager (RM Nurse) will ensure that the Fire Safety Plan policy is updated to include these items. IP Director and HR Director will ensure IP staff are trained on fire control plan annually.</p> <p>+ QI coordinator will verify initial</p>	04/30/2021	

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

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	<p>c) Emergency phone call to fire department. The facility did not address calling the fire department after activation of the fire alarm system or discovery of fire.</p> <p>Based on interview at the time of records review, the Quality Improvement Assistant looked through the fire safety plan and stated the aforementioned items were not in the provided plan.</p> <p>This finding was reviewed with the Maintenance Coordinator, the Maintenance Forman, and the Quality Improvement Assistant at the exit conference.</p>		<p>training occurs and that policy is reviewed annually and updated as needed.</p>		