

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/03/2014
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NAME OF PROVIDER OR SUPPLIER  SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b).</p> <p>Survey Date: 06/03/14</p> <p>Facility Number: 004975 Provider Number: 150163 AIM Number: 200816530A</p> <p>Surveyors: Mark Bugni, Life Safety Code Specialist, Lex Brashear, Life Safety Code Specialist and Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Catherine Regional Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>This three story hospital was determined to be of Type II (222) construction with a basement and partially sprinkled. The basement kitchen, dining room, and old bathroom; the first floor physical therapy</p>	K010000		

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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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K010018	<p>room, the gift shop, and the third floor hyperbaric chamber room were sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The facility has a capacity of 47 and had a census of 27 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure the 6 of 200 corridor doors latched into the door frames and would resist the passage of smoke. This deficient practice could affect at least 10 patients, staff and visitors on the second floor, all patients on the third floor behavior unit, and all patients, staff and visitors who use the basement canteen.</p> <p>Findings include:</p> <p>Based on observations with the HVAC-Plant Operations and Tech-Plant Operations staff and Director of Facilities from 10:30 a.m. to 1:30 p.m. on 06/03/14, the following was noted:</p> <p>a. The door to room 367 did not latch into the frame.</p> <p>b. The door to room 217 did not latch into the frame.</p> <p>c. The door to the basement sterilizer room had a two inch gap along the latching side of the door in the closed position.</p> <p>d. The door to the basement housekeeping storage room had two, one half inch circular holes through the door next to the door knob.</p> <p>e. The double doors to the hyperbaric chamber room failed to positively latch into the door frame and had a manual</p>	K010018	<p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1a.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency corrected on June 19, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The door to room 367 was repaired &amp; lubricated</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Review on weekly walk through and document retained in the Facility Management office.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 2014</p>	07/25/2014

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	<p>slide bolt latch at the top of each door.</p> <p>f. The door to room 246 failed to latch into the door frame on several attempts and left a one inch gap when closed. This was verified by the HVAC-Plant Operations staff, Tech-Plant Operations staff, and Director of Facilities at the time of observations and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of 200 doors protecting corridor openings did not have an impediment to closing. This deficient practice could affect at least 10 patients, staff and visitors on the second floor, all patients on the third floor behavior unit, and all patients on the first floor emergency room.</p> <p>Findings include:</p> <p>Based on observations with the HVAC-Plant Operations staff and Tech-Plant Operations staff from 10:00 a.m. to 2:45 p.m. on 06/03/14, the following was noted:</p> <p>a. The door to room 350 (office) was propped open with a wooden wedge under the door.</p> <p>b. The door to the Behavioral Health Services office was propped open with a wooden wedge under the door.</p>		<p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1b.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 25, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The doors to the room 217 were assessed for repair.</p> <p>Due to the age of the doors and their unusual design we are working with the manufacturer to find parts for the repair on the mechanisms. The doors will be repaired when the manufacturer identifies a vendor to provide the parts.</p>				

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	<p>c. The door to the first floor ER Treatment room was propped open with a wooden wedge under the door.</p> <p>d. The door to room 310 was propped open with a wooden chair.</p> <p>This was verified by the HVAC-Plant Operations and Tech-Plant Operations staff at the time of observation, and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m. open.</p>		<p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Repairs will be completed when the parts become available. The manufacturer will be providing the hospital with a vendor name that can supply the needed parts.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction will be completed within 30 days of the receipt of the needed parts.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1c.</b></p>		

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			<p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 25, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The doors to the sterilizer room were assessed for repair.</p> <p>Due to the age of the doors and their unusual design we are working with the manufacturer to find parts for the repair on the mechanisms. The doors will be repaired when the manufacturer identifies a vendor to provide the parts.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Repairs will be completed when the parts become available. The manufacturer will be providing the hospital with a vendor name that can supply the needed parts.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p>		

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			<p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction will be completed within 30 days of the receipt of the needed parts.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1d.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 19, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The Maintenance staff repaired the holes in the door and installed a door handle plate.</p>		

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			<p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The repair was completed June 19, 2014</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>Project completed.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The door handle plate is part of the door handle mechanism.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1e.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by June 30, 2014</p> <p><b>WHAT IS THE PLAN OF</b></p>		

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			<p><b>CORRECTION:</b></p> <p>The door will be equipped with a latching hardware.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The Maintenance department will purchase a positive latching mechanism to install on the door that will latch when closed.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>June 26, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The equipment that will be installed will be a permanent installation.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 1f.</b></p>		

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			<p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 25, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The doors to room 246 were assessed for repair.</p> <p>Due to the age of the doors and their unusual design we are working with the manufacturer to find parts for the repair on the mechanisms. The doors will be repaired when the manufacturer identifies a vendor to provide the parts.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Repairs will be completed when the parts become available. The manufacturer will be providing the hospital with a vendor name that can supply the needed parts.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p>		

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			<p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction will be completed within 30 days of the receipt of the needed parts.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 2a.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 5, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The door stop in room 350 was removed and the staff member was informed the wooden stops could not be used on the corridor doors.</p>		

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			<p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The door stop was removed on June 5, 2014</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 5, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The Director of Facilities will monitor the area during the weekly rounds. All staff will be reminded that door stops cannot be used on corridor doors.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 018 2b.</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 5,</p>	

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K010020	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to maintain the vertical opening protection for 2 of 4 basement exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a</p>	K010020	<p>2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The door stop in the Behavioral Health Services office was removed and the staff member was informed the wooden stops could not be used on the corridor doors.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The door stop was removed on June 5, 2014</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 020</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p>	07/25/2014	

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	<p>fire resistance rating of at least one hour. This deficient practice could affect any patient, staff and visitor.</p> <p>Findings include:</p> <p>Based on observations on 06/03/14 during a tour of the basement with the Director of Facilities from 10:00 a.m. to 2:45 p.m., the kitchen stairway door and the canteen area stairway door each failed to self close and latch into the door frame, leaving a one inch gap along the latching side of the doors. This was verified by the Director of Facilities at the time of observations and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p>		<p>Deficiency will be corrected by July 25, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The door to the basement stairwell was assessed for repair.</p> <p>Due to the age of the doors and their unusual design we are working with the manufacturer to find parts for the repair on the mechanisms. The doors will be repaired when the manufacturer identifies a vendor to provide the parts.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Repairs will be completed when the parts become available. The manufacturer will be providing the hospital with a vendor name that can supply the needed parts.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p>		

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K010027	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observations and interview, the facility failed to ensure 2 of 3 basement sets of smoke barrier doors and 1 of 9 third floor sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier</p>	K010027	<p>The correction will be completed within 30 days of the receipt of the needed parts.</p> <p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 027</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency corrected on June 19, 2014</p>	06/29/2014	

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	<p>shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect patients as well as staff and visitors.</p> <p>Finding include:</p> <p>Based on observations with the Director of Facilities on 06/03/14 during a tour of the basement from 10:00 a.m. to 2:45 p.m., the set of smoke barrier doors by the pharmacy and the set of smoke barrier doors by the linen room failed to close completely, leaving a one inch gap where each set of doors came together. Furthermore, based on observation with the HVAC-Plant Operations and Tech-Plant Operations staff at 10:30 a.m. on 06/03/14, a door closer on one of the third floor sets of smoke barrier doors in the corridor near room 363 was disconnected and would not self close to form a smoke resistive barrier. The basement pharmacy, basement linen room and near room 363 on the third floor sets of smoke barrier doors not closing completely was verified by the Director of Facilities and HVAC-Plant Operations and Tech-Plant Operations staff at the time of observations and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p>		<p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>Door outside of the Pharmacy and Linen rooms were repaired &amp; lubricated</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Review on weekly walk through and document retained in the Facility Management office.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 2014</p> <p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to</p>		

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			<p>the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 027</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency corrected on June 19, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The door closer was reinstalled on the smoke barrier doors near room 363</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Corrected on June 19, 2014.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 2014</p>	

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K010029	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 10 third floor and 2 of 6 basement hazardous areas, such as an area exceeding 50 square feet and storing combustible materials, and 1 of 1 gas fired equipment rooms were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect patients,</p>	K010029	<p><b>HOW THE DEFICIENCY REOCCURANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 029</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency corrected on June 19, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p>	07/25/2014

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	<p>staff and visitors using the basement canteen, and any patients, staff and visitors using the third floor Respiratory Therapy area.</p> <p>Findings include:</p> <p>a. Based on observations on 06/03/14 during a tour of the third floor with the HVAC-Plant Operations and Tech-Plant Operations staff on 06/03/14 at 10:30 a.m., the third floor Respiratory Therapy Storage room (Room #375) door lacked a self closing device. This room exceeded 50 square feet and was used for storage of respiratory supplies wrapped in plastic and stored in cardboard boxes.</p> <p>b. Based on observation with the Director of Facilities during a tour of the basement from 10:00 a.m. to 2:45 p.m., the basement's gas fired boiler room set of doors failed to self close and latch into the door frame on three separate attempts. The one hundred and forty square foot pharmacy storage room where twenty two cardboard boxes of pharmacy supplies were stored, and the sixty square foot copy machine room where eighteen plastic copy machines and six cardboard boxes filled with printer cartridges were stored each lacked self closing devices on the doors. This was verified by the HVAC-Plant Operations and Tech-Plant Operations</p>		<p>A door closing device was installed on the door leading to the Respiratory Therapy storeroom (#375).</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Corrected on June 19, 2014.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 2014</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The equipment is a permanent installation. The door will remain closed.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 029</b></p> <p><b>DATE DEFICIENCY WILL BE</b></p>				

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	staff and Director of Facilities at the time of observations and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.		<p><b>CORRECTED:</b></p> <p>Deficiency will be corrected by July 25, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The doors to the basement mechanical room were assessed for repair.</p> <p>Due to the age of the doors and their unusual design we are working with the manufacturer to find parts for the repair on the mechanisms. The doors will be repaired when the manufacturer identifies a vendor to provide the parts.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Repairs will be completed when the parts become available. The manufacturer will be providing the hospital with a vendor name that can supply the needed parts.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p>		

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			<p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction will be completed within 30 days of the receipt of the needed parts.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 029</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 19, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>Door closing hardware was purchased and installed on the Pharmacy storeroom door.</p>		

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			<p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The door closing hardware was installed and checked for operation.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 214</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ISDH PLAN OF CORRECTION</b></p> <p><b>ID PREFIX TAG: K 029</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 19,</p>	

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			<p>2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>Door closing hardware was purchased and installed on the copier storeroom door.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The door closing hardware was installed and checked for operation.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The correction was completed on June 19, 214</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The maintenance department will monitor the doors during their daily</p>	

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K010046	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview; the facility failed to ensure 2 of 2 battery operated emergency lights in the Physical Therapy addition were maintained and functioned in accordance with LSC 7.9. LSC 7.9.2.5 requires the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any patient, staff or visitor using the Physical Therapy addition.</p>	K010046	<p>rounds and document any discrepancies on their form. If any are identified it will be reported to the Director of Facilities.</p> <p><b>ID PREFIX TAG: K 046 DATE DEFICIENCY WILL BE CORRECTED:</b> Deficiency will be corrected by June 30, 2014 <b>WHAT IS THE PLAN OF CORRECTION:</b> New dry cell batteries were ordered. For the emergency lights in the Physical Therapy department. The lights are also supported by the hospital emergency generator. <b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b> When the batteries are received from the vendor they will be installed in the fixtures. <b>WHO IS RESPONSIBLE:</b> Director of Facilities Management <b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b> The batteries were ordered on June 13, 2014 <b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b> The maintenance department will monitor monthly and document on the test log located in the Maintenance shop.</p>	06/30/2014

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K010050	<p>Findings include:</p> <p>Based on observation with the HVAC-Plant Operations and Tech-Plant Operations staff from 10:30 a.m. to 1:30 p.m. on 06/03/14, the two battery operated emergency lights in the Physical Therapy addition did not function when tested. Based on interview at the time of observation, the HVAC-Plant Operations and Tech-Plant Operations staff verified the aforementioned battery operated emergency lights did not function when tested. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on 1 of 3 shifts during the past</p>	K010050	<p><b>ID PREFIX TAG: K 050</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p>	06/10/2014			

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	<p>year. This deficient practice affects all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the Fire Drill Evacuation/Fire Report Checklist with the Director of Facilities on 06/03/14 at 10:15 a.m., fire drills conducted on the third shift were held at the following similar times: on 01/24/14 at 6:15 a.m., on 04/10/14 at 6:30 a.m., and on 07/09/13 at 6:30 a.m. Based on an interview with the Director of Facilities on 06/03/14 at 10:30 a.m., the third shift starts at 11:00 p.m. and ends at 7:00 a.m. The third shift fire drills being held at similar times was verified by the Director of Facilities at the time of record review and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p>		<p>Deficiency was corrected on June 10, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The fire drill schedule was revised to ensure that the fire drills are at varying times to ensure that staff is tested at different times of the day or night.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>When drills are scheduled the date and time of implementation will be written on the form. Staff performing the drill will complete the form and submit it to the Director of Facilities.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The plan was revised and implemented on June 10, 2014</p>	

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K010051	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>1. Based on record review and interview, the facility failed to ensure 42 of 67 smoke detectors tested for sensitivity were either cleaned and recalibrated, or replaced. NFPA 72, National Fire</p>	K010051	<p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The maintenance department will follow the date and time on the form when they complete a drill. The form will be given to the Director of Facilities whom will report the drill information to the Safety Committee.</p> <p><b>ID PREFIX TAG: K 051</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will by corrected on July 30, 2014</p>	07/30/2014
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	<p>Alarm Code, at 7-3.2 requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(i) refers to 7-3.2.1 which requires Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test</li> </ol>		<p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The first fifteen smoke detectors were replaced in July of 2013. The second 15 detectors have been scheduled for the first week of July 30, 2014. The remaining detectors will be installed by the end of July 30, 2014.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Koorsen Fire &amp; Security have been scheduled to install the next fifteen smoke detectors the first week of July 30, 2014. The remaining detectors will be scheduled to be installed by the end of July 30, 2014.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The plan is partially implemented. The remaining smoke detectors will be installed by the end of July 30, 2014.</p>		

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	<p>methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of Koorsen Fire &amp; Security Detector Sensitivity Test Reports dated 09/17/12 and 09/25/12 with the Director of Facilities on 06/03/14 at 10:30 a.m., the reports listed fifty seven smoke detectors which failed sensitivity testing. Furthermore, the Koorsen Fire &amp; Security Service Work Order report dated 07/14/13 indicated the Tech Replaced 15 Smoke Detectors, but the report was not specific as to which smoke detectors had been replaced.</p> <p>Based on an interview with the Director of Facilities on 06/03/14 at 10:40 a.m., it was stated the facility is replacing the failed smoke detectors over time because of the cost involved with replacement. The forty two failed smoke detectors not</p>		<p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The detectors will upgrade the fire systems of the hospital. The new devices will be tested on a regular schedule.</p> <p><b>ID PREFIX TAG: K 051</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 24, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The smoke detector located in the third floor TV room was between the supply air and return air vents. The smoke detector was removed and relocated over three feet from the vents.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The smoke detector was removed and relocated. The detector is in a new location three feet from the supply and return vents.</p>		

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	<p>being replaced or recalibrated was verified by the Director of Facilities at the time of record review, and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 67 smoke detectors in the facility connected to the fire alarm system were properly separated from an air supply or return vent. NFPA 72, National Fire Alarm Code, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect at least 10 patients as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the HVAC-Plant Operations and Tech-Plant Operations staff from 10:30 a.m. to 1:30 p.m. on 06/03/14, the following was noted:</p> <p>a. A smoke detector located in the third floor TV room was situated between a supply air vent and a make up air vent and was one foot away from either vent.</p> <p>b. A smoke detector located in the third floor soiled linen room was one foot from an air supply vent.</p>		<p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The smoke detector was moved on June 24, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The detectors are in a permanent location away from the vents.</p> <p><b>ID PREFIX TAG: K 051</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 24, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The smoke detector located in the third floor laundry room was within a foot of the supply air. The smoke detector was removed and relocated</p>	

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K010062	<p>c. A smoke detector located in the third floor personal laundry room was two feet from an air supply vent.</p> <p>Based on interview at the time of observation, the HVAC-Plant Operations and Tech-Plant Operations staff verified the distances between the vents, and agreed the air flow could interfere with smoke detector function. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>		<p>over three feet from the vents.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The smoke detector was removed and relocated. The detector is in a new location three feet from the supply and return vents.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The smoke detector was moved on June 24, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The detectors are in a permanent location away from the vents.</p>	

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	<p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 3 of 3 sprinkler system gauges were replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of Quarterly Sprinkler System Inspection Reports from 03/17/14 through 01/03/13 with the Director of Facilities on 06/03/14 at 10:40 a.m., there was no record the three sprinkler system gauges had been replaced over the past five years. Based on observation of the sprinkler riser, located in the basement boiler room on 06/03/14 at 10:45 a.m. with the Director of Facilities, there were three gauges on the sprinkler riser with a manufacturer date of 2008 on two gauges and no manufacturer date on the one gauge. The lack of the three sprinkler system gauges being replaced every five years was verified by the Director of Facilities at the time of observation of the</p>	K010062	<p><b>ID PREFIX TAG: K 062</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 3, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The gauges on the sprinkler system/fire pump have been ordered from Koorsen Fire &amp; Security.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The new gauges have been ordered and will be installed when received.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The new gauges were ordered from Koorsen Fire &amp; Security on June 24, 2014.</p>	07/03/2014

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K010070	<p>sprinkler system riser and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to ensure a policy and procedure was available for the operation 1 of 1 space heaters to ensure the unit was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice would not affect patients but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the HVAC-Plant Operations and Tech-Plant Operations staff from 10:30 a.m. to 1:30 p.m. on 06/03/14, a portable space heater was plugged into an electrical outlet and</p>	K010070	<p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The gauges are included in the fire systems inspection each quarter. The fire/sprinkler system gauges will monitored and replaced every five years.</p> <p><b>ID PREFIX TAG: K 070</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 5, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The portable space heater was removed from the Medical Staff office area. The device did not meet the established guidelines and UL approval.</p>	06/05/2014

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	<p>appeared to be in use in the medical staff office. The HVAC-Plant Operations and Tech-Plant Operations staff said at the time of observation, they were unaware there was a space heater in the facility. They were unaware of a policy and procedure for the use of space heaters to identify where they might be used and any restrictions related to their use in the facility. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p>		<p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The device was removed from the Medical Staff office and disposed of on the June 5, 2014.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The device was removed on June 5, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The revised policy was submitted to the departments outlining the requirements and permissible locations for them. The staff in each department will sign a form that states that they reviewed the policy.</p> <p><b>ID PREFIX TAG: K 070</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 5,</p>		

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			<p>2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The policy for the use of space heaters was revised and submitted to the department for their staff review.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>After the review each employee must sign the form showing that they had reviewed the policy. At no time is a space heater to be used in a patient care area.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The plan review began on June 19, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p>		

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K010072	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 3 exits. This deficient practice could affect any patient, staff or visitor using the south exit stairwell in the event of an emergency.</p> <p>Finding include:</p> <p>Based on observation with the HVAC-Plant Operations and Tech-Plant Operations staff from 10:30 a.m. to 1:30 p.m. on 06/03/14, the bushes outside the south exit were overgrown and protruding into the exit discharge path, covering half of the sidewalk. Based on interview at the time of observation, the</p>	K010072	<p>The revised policy was submitted to the departments outlining the requirements and permissible locations for them. The staff in each department will sign a form that states that they reviewed the policy.</p> <p><b>ID PREFIX TAG: K 072</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 18, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The bushes outside of the South exit was removed.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The Maintenance staff cut the bushes to the ground level.</p>	06/18/2014

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K010130	<p>HVAC-Plant Operations and Tech-Plant Operations staff verified the means of egress was not continuously maintained free of impediments at the south exit. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 1 of 10 inspection certificates was current to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all patients, staff and visitors.</p>	K010130	<p><b>WHO IS RESPONSIBLE:</b>  Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b>  The bushes were removed on June 18, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b>  The bushes were cut to the ground. The area where the bushes were will have flowers planted.</p> <p><b>ID PREFIX TAG: K 130</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b>  The boiler certification certificate with a 2015 expiration date is available.</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b>  The certificate was found that shows</p>	06/03/2014

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K010144	<p><b>Findings include:</b></p> <p>Based on review of the ten boiler/hot water heater inspection certificates with the Director of Facilities on 06/03/14 at 11:05 a.m., the inspection certificate for the Lochnivar model hot water heater with the Indiana Registration #281834 had an expiration date of 03/14/13. Based on an interview with the Director of Facilities on 06/03/14 and observation of the Lochnivar model water heater located in the basement boiler room, there was no current inspection certificate in the boiler room. The lack of a current inspection certificate for the Lochnivar model hot water heater was verified by the Director of Facilities at the time of record review and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1</p>	K010144	<p>that the inspection is not due until 2015.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The Director of Facilities has the certificate with the due date of 2015.</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>Certificate is available.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The hospital and insurance company continually monitors compliance with the boiler certificates.</p>	07/30/2014	

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	<p>emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply.</li> <li>5. Overcrank (failed to start).</li> <li>6. Overspeed.</li> </ol> <p>Where a regular work station will be</p>		<p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 30, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The hospital contacted Whyne Supply for a quote on installing a remote annunciator panel in the Registration office.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Whyne Supply will provide a quote for the installation of an additional annunciator panel in the Registration office..</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The company was contacted on June 19, 2014. A quote will be received by June 30, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER  SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the patients as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/03/14 at 12:10 p.m. during a tour of the facility with HVAC/Plant Operations and Tech/Plant Operations staff, there was no remote alarm annunciator for the emergency generator in a location readily observed by operating personnel at a regular work station such as a nurses' station. Furthermore, the only remote alarm annunciator for the generator was located in the Business Office which was not occupied at all times. This was verified by HVAC/Plant Operations and Tech/Plant Operations staff at the time of observation who confirmed the Business Office was not occupied at all times, and acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>2. Based on observation and interview,</p>		<p><b>HOW THE DEFICIENCY REOCCURRENCE WILL BE PREVENTED:</b></p> <p>The installation of the equipment will be a permanent installation. The Registration office is occupied 24 hours a day.</p> <p><b>ID PREFIX TAG: K 144</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency will be corrected by July 30, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>The hospital contacted Whyne Supply for a quote on installing a remote manual shut-off for the generator.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>Whyne Supply will provide a quote for the installation of an emergency manual shut-off on the exterior of the enclosure that houses the emergency generator.</p> <p><b>WHO IS RESPONSIBLE:</b></p>				

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NAME OF PROVIDER OR SUPPLIER  SAINT CATHERINE REGIONAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111			
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	<p>the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/03/14 between 10:30 a.m. and 2:00 p.m. during a tour of the facility with HVAC/Plant Operations and Tech/Plant Operations staff, a remote shut off device for the generator was not found. Based on interview at 12:22 p.m. while at the generator, the HVAC/Plant Operations</p>		<p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The company was contacted on June 19, 2014. A quote will be received by June 30, 2014</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>The installation of the equipment will be a permanent installation. The equipment will be installed on the exterior of the building that houses the generator.</p>				

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K010147	<p>staff person said the generator was over 150 Horsepower and verified there was no remote shut off device for the generator. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure flexible cord electrical wiring used in the business office was in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure.</li> <li>2. Where run through holes in the walls, structural ceilings, suspended ceilings, dropped ceilings; or floors.</li> <li>3. Where run through doorways, windows, or similar openings.</li> <li>4. Where attached to building surfaces.</li> <li>5. Where concealed behind walls, structural ceilings, dropped ceilings or floors.</li> <li>6. When installed in raceways, except otherwise permitted in this Code.</li> </ol> <p>This deficient practice could affect any</p>	K010147	<p><b>ID PREFIX TAG: K 147</b></p> <p><b>DATE DEFICIENCY WILL BE CORRECTED:</b></p> <p>Deficiency was corrected on June 10, 2014</p> <p><b>WHAT IS THE PLAN OF CORRECTION:</b></p> <p>Maintenance removed the 15 foot orange extension cord that was providing temporary power to the display case by the business office.</p> <p><b>HOW THE PLAN OF CORRECTION WILL OCCUR:</b></p> <p>The maintenance staff removed the orange cord from the display case on</p>	06/10/2014

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	<p>patient, staff or visitor using the 1st floor main corridor.</p> <p>Findings include:</p> <p>Based on observation on 06/03/14 during a tour of the facility from 10:30 a.m. to 1:30 p.m. with the HVAC-Plant Operations and Tech-Plant Operations staff, there was 15 foot length of orange electrical cord that was plugged into an electrical outlet in the Business office and went up the wall, under the lay-in ceiling tile and was spliced into an electrical cord with a switch that was attached to a light at the top of a curio cabinet built into the first floor main corridor wall.</p> <p>Based on interview at the time of observation, the HVAC-Plant Operations and Tech-Plant Operations staff acknowledged the orange electrical cord in the business office. This was acknowledged by the Executive Director at the exit conference on 06/03/14 at 2:45 p.m.</p>		<p>June 10, 2014</p> <p><b>WHO IS RESPONSIBLE:</b></p> <p>Director of Facilities Management</p> <p><b>WHEN THE PLAN OF CORRECTION WILL BEGIN:</b></p> <p>The removal of the cord was completed on June 10, 2014.</p> <p><b>HOW THE DEFICIENCY REOCCURRANCE WILL BE PREVENTED:</b></p> <p>Lighting for the display case by the business office will not be illuminated. No power will be installed to the display case.</p>	