STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151500	A. BUILDING 01 B. WING	08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICE OF THE CALUMET AREA INC	600 SUPERIOR AVE MUNSTER, IN 46321

(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
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.100(d). Survey Date: 08/31/16 Facility Number: 005787 Provider Number: 151500 AIM Number: 200141650A At this Life Safety Code survey, Hospice of the Calumet Area Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 418.100(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). The original building consisting of suites 1 through 6 and common living areas was surveyed with Chapter 19, Existing Health Care Occupancies This one story facility, built in 1998, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 8	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	and had a census of 8 at the time of this survey. Quality Review completed on 09/06/16 - DA			
K 0044 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 1 fire door set was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect all occupants. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 at 11:34 a.m., the Entrance fire doors failed to close and latch when tested. Based on interview at the time of observation, the Patient Care	K 0044	On 9/6/2016 maintenance man lubricated hinges and the fire doors now close and latch readily. Confirmed on 9/9/2016 by the Executive Director (ED). Checking of fire doors was added to monthly fire system inspection log and compliance reconfirmed by the Patient Care Coordinator (PCC) on 9/29/2016. PCC is responsible for compliance.	09/09/2016

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	Coordinator and the Executive Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0048 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review and interview	K 0048	On 9/28/2016, the Disaster Management policy was updated to include evacuation of a smoke compartment at the facility (see attached). The policy was reviewed with nursing staff at the 9/29/2016 Nurse meeting. A memo was distributed on 9/29/2016 at the facility for all staff and volunteers. PCC or designee will review understanding and compliance during monthly fire drills beginning 9/29/2016. PCC is responsible for compliance.	09/29/2016

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	on 08/31/16 at 12:21 p.m., the Patient Care Coordinator and the Executive Director acknowledged the "Disaster Management Plan" did not address evacuation of a smoke compartment. 3.1-19(b)			
K 0050 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.	K 0050	The PCC or trained designee conducts a monthly fire drill which includes activating the fire alarm. The alarm company is notified in advance of the drill; confirmation of the signal being received will be confirmed by the PCC or designee conducting the drill and it will be documented on the fire drill form. New process initiated on 9/29/2016. ED will check Fire Drill logs monthly x3 to verify compliance. ED is responsible for compliance.	09/29/2016

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	This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Fire Drill Evaluation" with the Patient Care Coordinator and the Executive Director on 08/31/16 at 10:38 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Patient Care Coordinator and the Executive Director acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)			
K 0056 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific			

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HOSPICE OF THE CALUMET AREA INC	600 SUPERIOR AVE MUNSTER, IN 46321

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	areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Based on observation and interview, the facility failed to ensure the spray pattern sprinkler in 1 of 1 sun room and 6 of 6 resident rooms was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect all occupants. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 between 11:15 a.m. and 12:32 p.m., in resident room #1, #2, #3, #4, #5, and #6, all rooms had a ceiling fan in the middle of the room. Additionally, all rooms had a sprinkler head installed above the ceiling fan. Based on interview at the time of each observation, the Patient Care Coordinator and the Executive Director acknowledged	K 0056	Representatives from F.E. Moran, Inc., Fire Protections of Northern Illinois evaluated the rooms on 9/21/16 and 9/23/16. They concluded that the ceiling fan has acceptable spacing from the 4 sprinkler heads in rooms 7 and 8 and cited NFPA 13, Section8-10.6.2.1.9* - 2010 edition in relation to the blades of the ceiling fan. See attached documentation. If the ISDH does not agree with the resolution, ED will be responsible for having Emcor *Hyre Electric* remove and cap the ceiling fans in Rooms 7 and 8 within 2 weeks of the determination. The ED is responsible for compliance.	10/07/2016

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	the abovementioned condition. 3.1-19(b)			
K 0064 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Pantry and 1 of 1 Garage Storage fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all occupants. Findings include: Based on observation and interview with the Patient Care Coordinator and the Executive Director on 08/31/16 at 11:31 a.m. then again at 11:43 a.m., a Pantry fire extinguisher maintenance tag indicated the last six year test was completed 07/08. Then again a Garage Storage fire extinguisher maintenance tag indicated the last six year test was completed 06/03. Based on interview at	K 0064	On 9/20/2016, Foster & Sons replaced the fire extinguishers in the garage and pantry with extinguishers that were in compliance with the 6-yr testing requirement. The PCC or designee will check for compliance with the 6 year testing during the monthly fire extinguisher checks to ensure compliance. The PCC is responsible for compliance.	09/20/2016

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	the time of observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the aforementioned condition. 3.1-19(b)			
K 0069 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 1 kitchen. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors using the Gables pantry kitchen. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 at 11:29 p.m., the cooking equipment in the Gables pantry	K 0069	The facility's kitchen is equipped with a residential stove which does not have any high BTU burners. It also has an additional built in oven which is used once a year for baking holiday cookies. Patients residing in our facility are at the very end of life. On average facility patients live for 5 - 6 days and most do not eat at all. Therefore, we do very little meal preparation. The majority of our "cooking" consists of warming meals in the microwave. The range top is used for warming soups and occasionally making scrambled eggs. A Class K fire extinguisher is located approximately 6 ft. from the stove. On 9/28/16, staff and volunteers were notified verbally and memos were posted in writing (9/30/16) and sent to volunteers that no cooking is it to take place which will produce grease laden vapors (see attached memo). Volunteer Coordinator will check the	09/30/2016

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	kitchen was not protected by automatic fire-extinguishing equipment in compliance with the Standard UL 300, Fire Testing of Fire Extinguishing Systems for protection of Restaurant Cooking areas or equivalent standards. Based on interview at the time of observation, the Patient Care Coordinator and the Executive Director confirmed that all meals including meats such as bacon and sausage are cooked in the kitchen. 3.1-19(b)		refrigerator and kitchen for evidence of any frying, broiling, or other cooking that would produce grease laden vapors: weekly x4, then monthly x3. PCC is responsible for compliance.	
K 0076 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Based on observation and interview, the facility failed to ensure 3 of 3 cylinders in Dirty Utility room of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder	K 0076	Rack to store oxygen cylinders was installed in the dirty utility room and oxygen cylinders were removed by DME/Oxygen provider on 9/21/2016. Staff notified of need for oxygen cylinders to be supported in a stand	09/29/2016

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	or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 at 11:56 a.m., the Dirty Utility room had three oxygen cylinders that were freestanding on the floor. Based on interview at the time of observation, the Patient Care Coordinator and the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		or cart and use of new rack for cylinders inadvertently left at facility without their own support device. Memo distributed to staff on 9/29/2016 to reinforce teaching. PCC or designee will monitor monthly during monthly fire safety inspections. PCC is responsible for compliance.	
K 0144 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily	K 0144	1. Vendor will have generator annunciator panel and parts on 10/3/2016. Emcor *Hyre Electric* will complete needed electrical work for panel by 10/7/2016. Alternative Energy Solutions will complete install, program and test panel on	10/10/2016

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	observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents. Findings include: Based on an observation with the Patient Care Coordinator and the Executive Director on 08/31/16 between 11:15 a.m.and 12:32 p.m., no generator annunciator panel was discovered. Based on interview at the time of observation, the Patient Care Coordinator and the Executive Director acknowledged the aforementioned condition and confirmed that no generator annunciator panel was discovered. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This		10/10/2016. ED is responsible for compliance. 2. Facility maintenance individual responsible for generator testing was notified of need to document the amount of time it takes for the power transfer during the monthly power transfer testing by the PCC on 9/1/2016. He is aware that the transfer should occur within 10 seconds. The PCC will monitor for compliance monthly x3, then make periodic random checks for compliance. Compliance by 9/30/2016. The PCC is responsible for this plan.	

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	deficient practice could affect all staff, residents, and visitors. Findings include: Based on record review with the Patient Care Coordinator and the Executive Director on 08/31/16 at 11:34 a.m., the monthly testing forms failed to include the transfer time for twelve months of the last twelve months of testing. In the transfer time column was written in as "ok." Based on interview at the time of record review, the Patient Care Coordinator and the Executive Director acknowledged the aforementioned condition. 3-1.19(b)			
K 0147 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, 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	K 0147	On 9/1/2016, the multi-plug adaptor was removed from the outlet and building. Staff were instructed that use of multi-plug adaptors is not permitted. PCC and ED have been monitoring weekly for compliance x4. Memo distributed to staff on 9/29/2016 to reinforce teaching. Additional fixed wiring outlets will be added to Nurses' Station to avoid problem	10/07/2016

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	practice could affect all occupants. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 at 12:24 p.m., a multiplug adapter was powering computer components in the Nurses' station. Based on interview at the time of observation, the Patient Care Coordinator and the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		from recurring in the future. Additional wiring will be completed on October 7, 2016. ED and PCC are responsible for compliance.	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.100(d). Survey Date: 08/31/16 Facility Number: 005787 Provider Number: 151500 AIM Number: 200141650A At this Life Safety Code survey, Hospice of the Calumet Area Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42	K 0000		

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	CFR Subpart 418.100(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Suites 7 and 8 were surveyed with Chapter 18, New Health Care Occupancies This one story facility was determined to be of Type V (111) construction and was fully sprinklered. This addition to the original building, completed in 2004, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Quality Review completed on 09/06/16 - DA			
K 0056 Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151500	A. BUILDING 02 B. WING	08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICE OF THE CALUMET AREA INC	600 SUPERIOR AVE MUNSTER, IN 46321

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	substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. Based on observation and interview, the facility failed to ensure the spray pattern sprinkler in 2 of 2 resident rooms was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect all occupants. Findings include: Based on observation with the Patient Care Coordinator and the Executive Director on 08/31/16 between 11:15 a.m. and 12:32 p.m., in resident room #7 and #8, both had a ceiling fan in the middle of the room. Additionally, both rooms had a sprinkler head installed above the ceiling fan. Based on interview at the time of observation, the Patient Care Coordinator and the Executive Director acknowledged the abovementioned condition.	K 0056	Representatives from F.E. Moran, Inc., Fire Protections of Northern Illinois evaluated the rooms on 9/21/16 and 9/23/16. They concluded that the ceiling fan has acceptable spacing from the 4 sprinkler heads in rooms 7 and 8 and cited NFPA 13, Section8-10.6.2.1.9* - 2010 edition in relation to the blades of the ceiling fan. See attached documentation. If the ISDH does not agree with the resolution, ED will be responsible for having Emcor *Hyre Electric* remove and cap the ceiling fans in Rooms 7 and 8 within 2 weeks of the determination. The ED is responsible for compliance.	10/21/2016

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	3.1-19(b)			