PRINTED:	11/01/2016
FORM API	PROVED
OMB NO. ()938-0391

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

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 151500		(X2) MULTIPLE CC A. BUILDING B. WING	01	COM	e survey pleted 1/2016
	PROVIDER OR SUPPLIE		600 SU	address, city, state, zip c PERIOR AVE FER, IN 46321	CODE	
(X4) ID PREFIX TAG K 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Bldg. 01	Survey was con	ode Recertification ducted by the Indiana nt of Health in accordance 8.100(d).	K 0000			
	Survey Date: 0 Facility Numbe Provider Numb AIM Number:	r: 005787 er: 151500				
	of the Calumet in compliance w Participation in CFR Subpart 42 from Fire and th	ety Code survey, Hospice Area Inc. was found not with Requirements for Medicare/Medicaid, 42 18.100(d), Life Safety ne 2000 edition of the rotection Association				
	The original bu 1 through 6 and	ife Safety Code (LSC). ilding consisting of suites common living areas was Chapter 19, Existing cupancies				
	determined to b construction and facility has a fir smoke detection sleeping rooms	acility, built in 1998, was e of Type V (111) d fully sprinklered. The re alarm system with n in the corridors, resident and spaces open to the facility has a capacity of 8				

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

TITLE

(X6) DATE

Any definencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 151500		A. BUILDI B. WING		COMPLETED 08/31/2016	
	PROVIDER OR SUPPLI		60	REET ADDRESS, CITY, STATE, ZIP CODE 0 SUPERIOR AVE JNSTER, IN 46321	1	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR		
	survey.	us of 8 at the time of this v completed on 09/06/16 -				
K 0044 Bldg. 01	NFPA 101 LIFE SAFETY C Horizontal exits, with 7.2.4. 19. Based on obser facility failed to set was arrange and latch. LSC horizontal exits 7.2.4 and 7.2.4 be self-closing accordance wit NFPA 80, Stan Windows at 2- mechanisms sh overcome fire to mechanism so achieved on ead deficient practi occupants. Findings incluce Based on obser Care Coordinat Director on 08/ Entrance fire da latch when test	vation and interview, the o ensure 1 of 1 fire door ed to automatically close 2 19.2.2.5 requires is to be in accordance with .3.8 requires fire doors to or automatic closing in h 7.2.1.8. In addition dard for Fire Doors and 1.4.1 requires all closing all be adjusted to resistance of the latch that positive latching is ch door operation. This ce could affect all	K 0044	On 9/6/2016 maintenance mar lubricated hinges and the fire of now close and latch readily. Confirmed on 9/9/2016 by the Executive Director (ED). Checking of fire doors was to monthly fire system insy log and compliance record by the Patient Care Coord (PCC) on 9/29/2016. PCC responsible for compliance	added bection firmed inator c is	

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

STATEMEN AND PLAN	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 151500 B. WING			(X3) DATE SURVEY COMPLETED 08/31/2016	
	PROVIDER OR SUPPLIE		600 SL	ADDRESS, CITY, STATE, ZIP CODE JPERIOR AVE TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE
TAG K 0048 Bldg. 01	Coordinator and acknowledged t condition. 3.1-19(b) NFPA 101 LIFE SAFETY CO There is a written all patients and for event of an emerg Based on record the facility faile plan that addres of 1 written fire requires a written fire safety plan following: (1) Use of alarm (2) Transmission department (3) Response to (4) Isolation of 2	DDE STANDARD plan for the protection of or their evacuation in the gency. 19.7.1.1 I review and interview, d to provide a written sed all components in 1 plans. LSC 19.7.2.2 en health care occupancy that shall provide for the alarms fire of immediate area	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
	(7) Preparationevacuation(8) Extinguishm	ractice could affect all			
	Based on a reco	rd review and interview			
M CMS 2567(0)	2-99) Previous Versions O	bsolete Event ID:	JT8I21 Facility	ID: 005787 If continuation sl	heet Page 3 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		,		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED	
		151500	B. WING		08/31	/2016	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COI	DE		
HOSPIC	E OF THE CALUM	ET AREA INC		SUPERIOR AVE ISTER, IN 46321			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	II D DE	(X5) COMPLETION DATE	
< 0050 Bldg. 01	Care Coordinate Director acknow Management Pl evacuation of a 3.1-19(b) NFPA 101 LIFE SAFETY CO Fire drills include alarm signal and fire conditions. Fi unexpected times at least quarterly familiar with proc drills are part of e Responsibility for drills is assigned who are qualified Where drills are of PM and 6:00 AM may be used inst 18.7.1.2, 19.7.1.2 Based on record the facility failed drills included t	12:21 p.m., the Patient or and the Executive vledged the "Disaster an" did not address smoke compartment. DDE STANDARD the transmission of a fire simulation of emergency re drills are held at s under varying conditions, on each shift. The staff is edures and is aware that established routine. planning and conducting only to competent persons to exercise leadership. conducted between 9:00 a coded announcement ead of audible alarms. d review and interview, d to ensure 12 of 12 fire he verification of the fire alarm signal to	K 0050	The PCC or trained designee conducts a monthly fire drill includes activating the fire al The alarm company is notifie advance of the drill; confirma	arm. d in	09/29/201	
	conducted betw p.m. for the last	station in fire drills een 6:00 a.m. and 9:00 4 quarters. LSC 19.7.1.2 t drills in health care		the signal being received will confirmed by the PCC or desi conducting the drill and it wil documented on the fire drill	gnee I be form.		
	occupancies sha transmission of			New process initiated on 9/29/2016. ED will chec Drill logs monthly x3 to v compliance. ED is respo for compliance.	ck Fire erify		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01 COMPLETED 151500 B. WING 08/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 SUPERIOR AVE HOSPICE OF THE CALUMET AREA INC MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 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 **NFPA 101** LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health Bldg. 01 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JT8I21 Facility ID: 005787 If continuation sheet Page 5 of 16

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	T OF HEALTH AND HU R MEDICARE & MEDIO						M APPROVED B NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>0</u> 1			COMPL	
		151500	B. WIN	IG	<u>•</u> ·	08/31/	2016
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			PERIOR AVE		
ноеріс	E OF THE CALUM				FER, IN 46321		
		-					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	prohibit sprinklers	e or local regulations s. 19.3.5, 19.3.5.1, NPFA					
	13	ation and index is the	12 00	57			10/07/201/
		vation and interview, the	K 00	30	Representatives from F.E. Moran, Inc., Fire Protections of Northern		10/07/2016
	-	ensure the spray pattern			Illinois evaluated the rooms on		
	-	f 1 sun room and 6 of 6			9/21/16 and 9/23/16. They		
		was unobstructed. NFPA			concluded that the ceiling fan has		
	25, 1998 Editio	n Standard for the			acceptable spacing from the 4		
	Inspection, Test	ting, and Maintenance of			sprinkler heads in rooms 7 and 8 a	nd	
	Water-Based Fi	re Protection Systems,			cited NFPA 13, Section8-10.6.2.1.9	* _	
	Section 2-2.1.2	states unacceptable			2010 edition in relation to the		
		spray patterns shall be			blades of the ceiling fan. See		
		A 13, 1999 Edition			attached documentation.		
		e Installation of Sprinkler			If the ISDH does not agree with the		
		5-6.5.1.2 states that			resolution, ED will be responsible f		
	-				having Emcor Hyre Electric remove and cap the ceiling fans in Rooms 7		
		en a sprinkler head an			and 8 within 2 weeks of the		
		than 1 foot away cannot			determination. The ED is		
		ne sprinkler head			responsible for compliance.		
		deficient practice could					
	affect all occup	ants.					
	Findings includ	e:					
	Based on observ	vation with the Patient					
	Care Coordinate	or and the Executive					
	Director on 08/2	31/16 between 11:15 a.m.					
	and 12:32 p.m.	in resident room #1, #2,					
	· ·	#6, all rooms had a					
		e middle of the room.					
	e	l rooms had a sprinkler					
	-	-					
		bove the ceiling fan.					
		iew at the time of each					
	· · · · · · · · · · · · · · · · · · ·	Patient Care Coordinator					
	I and the Executi	ve Director acknowledged	1		1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J

JT8I21 Facility ID:

Facility ID: 005787

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ULTIPLE C JILDING	ONSTRUCTION 01	. ,	TE SURVEY IPLETED
		151500	B. W.	ING		08/3	31/2016
NAME OF	PROVIDER OR SUPPLIE	ER .			ADDRESS, CITY, STATE, ZIP COI	DE	
HOSPIC	E OF THE CALUM	ET AREA INC			JPERIOR AVE TER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
	the abovementi	oned condition.					
	3.1-19(b)						
K 0064	NFPA 101 LIFE SAFETY C	ODE STANDARD					
Bldg. 01	inspected, and m occupancies in a NFPA 10. 18.3.5.6, 19.3.5.0 Based on obset facility failed to	nguishers shall be installed, naintained in all health care ccordance with 9.7.4.1, 6 evation and interview, the o ensure 1 of 1 Pantry and ctorage fire extinguishers	К 0	064	On 9/20/2016, Foster & Sons replaced the fire extinguisher garage and pantry with	's in the	09/20/2016
	requiring a 12-y emptied and su maintenance pr as required by 1 Portable Fire E	year hydrostatic test was bjected to the applicable ocedures every six years NFPA 10, Standard for xtinguishers Chapter icient practice could affect			extinguishers that were in compliance with the 6-yr test requirement. The PCC or designee wi for compliance with the 6 testing during the monthl extinguisher checks to et compliance. The PCC is responsible for complian	II check 5 year y fire nsure	
	Findings includ	e:					
	the Patient Care Executive Dire	vation and interview with e Coordinator and the etor on 08/31/16 at 11:31					
	fire extinguished indicated the la	at 11:43 a.m., a Pantry r maintenance tag st six year test was 8. Then again a Garage					
	Storage fire ext indicated the la	st six year test was 3. Based on interview at					

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

		IDENTIFICATION NUMBER: A. BUILDING 01 151500 B. WING			(X3) DATE SURVEY COMPLETED 08/31/2016	
	PROVIDER OR SUPPLIE		600 SL	ADDRESS, CITY, STATE, ZIP CODE JPERIOR AVE TER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0069 Bldg. 01	Supervisor and acknowledged to condition. 3.1-19(b) NFPA 101 LIFE SAFETY CC Cooking facilities accordance with Based on obser- facility failed to equipment with extinguishing sy LSC Sections 9 NFPA 96, 1998 Ventilation Cor of Commercial of 1 kitchen. N cooking equipm laden vapors (su deep fat fryers, woks, tilting ski shall be protector equipment. This affect any residevisitors using the Findings includ Based on obser- Care Coordinate Director on 08/2	9.2.3. 19.3.2.6, NFPA 96 vation and interview, the protect cooking a range hood ystem in accordance with .2.3 and 19.3.2.6 and Edition, Standard for throl and Fire Protection Cooking Operations in 1 FPA 96, 7-1.2 requires nent that produces grease then as but not limited to ranges, griddles, broilers, illets, and braising pans) ed by fire extinguishing s deficient practice could ent, as well as staff and e Gables pantry kitchen.	К 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 bakin holiday cookies. Patients residing i our facility are at the very end of life. On average facility patients liv for 5 - 6 days and most do not eat a all. Therefore, we do very little me preparation. The majority of our "cooking" consists of warming mea 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) a sent to volunteers that no cooking it to take place which will produce grease laden vapors (see attached memo). Volunteer Coordinator will check the	g n e at al als s ne	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		151500	B. WING		08/31/2016
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
	E OF THE CALUM		MUNS	STER, IN 46321	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		protected by automatic		refrigerator and kitchen for eviden of any frying, broiling, or other	ce
	-	ng equipment in		cooking that would produce grease	
	<u>^</u>	h the Standard UL 300,		laden vapors: weekly x4, then	
	-	Fire Extinguishing		monthly x3.	
		tection of Restaurant		PCC is responsible for	
	-	or equivalent standards.		compliance.	
		iew at the time of			
		Patient Care Coordinator			
	and the Executi	ve Director confirmed			
		cluding meats such as			
	bacon and saus	age are cooked in the			
	kitchen.				
	3.1-19(b)				
< 0076	NFPA 101				
		ODE STANDARD			
Bldg. 01		age and administration			
		otected in accordance with ard for Health Care			
	Facilities.				
		ge locations of greater than			
	3,000 cu.ft. are e separation.	nclosed by a one-hour			
		supply systems of greater			
		are vented to the outside.			
	4-3.1.1.2 (NFPA 18.3.2.4, 19.3.2.4	99), 8-3.1.11.1 (NFPA 99), 1			
		vation and interview, the	K 0076	Rack to store oxygen cylinders was	09/29/201
		ensure 3 of 3 cylinders in		installed in the dirty utility room ar	
	-	om of nonflammable		oxygen cylinders were removed by	
		xygen were properly		DME/Oxygen provider on	
	-	orted in a proper cylinder		9/21/2016.	
		IFPA 99, Health Care		Staff notified of need for oxygen	
		.11.2(h) requires cylinder		cylinders to be supported in a stan	d I
	racinues, 0-3.1	.11.2(II) requires cynnuer			~

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		151500	B. WING		08/31/2016
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
HOSPIC	E OF THE CALUM			JPERIOR AVE TER, IN 46321	
					(77)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
	or container res	straint shall meet NFPA		or cart and use of new rack for	
	99, 4-3.5.2.1(b)	27 which requires		cylinders inadvertently left at facilit	ty
		linders be properly		without their own support device.	
		ported in a proper cylinder		Memo distributed to staff on	
		This deficient practice		9/29/2016 to reinforce teaching. PCC or designee will monitor	
	could affect sta	•		monthly during monthly fire sa	
				inspections. PCC is responsib	
	Findings includ	le:		for compliance.	
	Based on obser	vation with the Patient			
	Care Coordinat	or and the Executive			
	Director on 08/	31/16 at 11:56 a.m., the			
	Dirty Utility ro	om had three oxygen			
		vere freestanding on the			
		interview at the time of			
	observation, the	e Patient Care Coordinator			
		ve Director acknowledged			
	the aforemention	•			
	3.1-19(b)				
K 0144	NFPA 101				
Bldg. 01		ODE STANDARD ected weekly and exercised			
Diug. UT) minutes per month and			
	shall be in accore	dance with NFPA 99 and			
	NFPA 110.				
	3-4.4.1 and 8-4.2 (NFPA 110)	2 (NFPA 99), Chapter 6			
		servation and interview,	K 0144	1 Mandan 111	10/10/201
	-	ed to ensure 1 of 1		1. Vendor will have generator annunciator panel and parts on	
	-	n accordance with NFPA		10/3/2016. Emcor <i>Hyre Electric</i>	e will
		n, Standard for Health		complete needed electrical work	
		NFPA 99, Section		panel by 10/7/2016. Alternative	
	3-4.1.1.15 requ	ires a remote annunciator		Energy Solutions will complete	
	to be provided	in a location readily		install, program and test panel or	n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151500	A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED 08/31/2016	
NAME OF	PROVIDER OR SUPPLIE	ER		REET ADDRESS, CITY, STATE, ZIP	CODE	
HOSPIC	E OF THE CALUN	IET AREA INC.		0 SUPERIOR AVE JNSTER, IN 46321		
	-					(775)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE
	observed by op	erating personnel at a		10/10/2016.		
		ation. In addition, NFPA		ED is responsible for com	pliance.	
	-	4.6.12.1 requires that any				
		ent or system required for		2. Facility maintenance responsible for genera		
		h this Code shall be		was notified of need to		
	continuously maintained. This deficient			the amount of time it t	akes for the	
	practice could affect all occupants in the			power transfer during	•	
	-	ng staff, visitors and		power transfer testing on 9/1/2016. He is av		
	residents.	C ,		transfer should occur		
				seconds.		
	Findings includ	le:		The PCC will monitor		
	1			compliance monthly x		
	Based on an ob	servation with the Patient		make periodic randon compliance. Complia		
		or and the Executive		9/30/2016. The PCC		
		31/16 between 11:15		responsible for this pla	an.	
		p.m., no generator				
	-	nel was discovered. Based				
	-	the time of observation,				
		e Coordinator and the				
		ctor acknowledged the				
		l condition and confirmed				
		or annunciator panel was				
	discovered.					
	3-1.19(b)					
		servation and interview,				
	-	ed to ensure 1 of 1				
	-	n accordance with NFPA				
		laintenance and Testing				
		hes states the general shall				
		as to be capable of				
		ce with the shortest time				
	practical and w	ithin 10 seconds. This				

CENTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151500	A. BUILDING B. WING	CONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 08/31/2016	
	PROVIDER OR SUPPLIE		600 \$	et address, city, state, zip coi SUPERIOR AVE ISTER, IN 46321	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	deficient praction residents, and v	ce could affect all staff, isitors.				
	Findings includ	e:				
	Director on 08/ monthly testing the transfer time last twelve more transfer time co "ok." Based on record review, the Coordinator and	or and the Executive 31/16 at 11:34 a.m., the forms failed to include e for twelve months of the ths of testing. In the lumn was written in as interview at the time of the Patient Care d the Executive Director the aforementioned				
K 0147 Bldg. 01	Electrical wiring a accordance with	ODE STANDARD and equipment shall be in National Electrical Code.				
	facility failed to adapter was not fixed wiring. N Electrical Code 400-8 requires to permitted, flexi not be used as a	18.9.1, 19.9.1 vation and interview, the o ensure 1 of 1 multiplug used as a substitute for FPA 70, National , 1999 Edition, Article that, unless specifically ble cords and cables shall a substitute for fixed cture. This deficient	K 0147	On 9/1/2016, the multi-plug was removed from the outlet building. Staff were instructe use of multi-plug adaptors is permitted. PCC and ED have been monit weekly for compliance x4. M distributed to staff on 9/29/2 reinforce teaching. Additiona wiring outlets will be added t Nurses' Station to avoid prob	t and ed that not coring lemo 2016 to al fixed to	10/07/2016

	R MEDICARE & MEDIC						MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION	. ,	(X3) DATE SURVEY	
			A. BUILDING <u>01</u> B. WING			COMPLETED	
		151500	B. WI				1/2016
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODF IPERIOR AVE	3	
HOSPIC	E OF THE CALUME	ET AREA INC			TER, IN 46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)		TAG	from recurring in the future.		DATE
	practice could al	ffect all occupants.			Additional wiring will be compl	eted	
	Eindings include				on October 7, 2016.		
	Findings include	5.			ED and PCC are responsi	ble for	
	Decod on obcom	ation with the Patient			compliance.		
		or and the Executive					
		1/16 at 12:24 p.m., a					
	multiplug adapte	-					
		onents in the Nurses'					
		n interview at the time of					
		Patient Care Coordinator					
		ve Director acknowledged					
	the aforemention	•					
	3.1-19(b)						
0000							
3ldg. 02							
	A Life Safety Co	ode Recertification	K 00	000			
	Survey was cond	ducted by the Indiana					
	State Departmen	t of Health in accordance					
	with 42 CFR 41	8.100(d).					
	Survey Date: 08	3/31/16					
	Facility Number	: 005787					
	Provider Numbe						
	AIM Number: 2	200141650A					
	At this Life Safe	ty Code survey, Hospice					
		Area Inc. was found not					
	in compliance w	ith Requirements for					
		Medicare/Medicaid, 42					
	_						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING COMPLETED 02 151500 B. WING 08/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 SUPERIOR AVE HOSPICE OF THE CALUMET AREA INC MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 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 **NFPA 101** LIFE SAFETY CODE STANDARD There is an automatic sprinkler system Bldg. 02 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JT8I21 Facility ID: 005787 If continuation sheet Page 14 of 16

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 02 151500 B. WING 08/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 SUPERIOR AVE HOSPICE OF THE CALUMET AREA INC MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 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 K 0056 Representatives from F.E. Moran, 10/21/2016 Inc., Fire Protections of Northern facility failed to ensure the spray pattern Illinois evaluated the rooms on sprinkler in 2 of 2 resident rooms was 9/21/16 and 9/23/16. They unobstructed. NFPA 25, 1998 Edition concluded that the ceiling fan has Standard for the Inspection, Testing, and acceptable spacing from the 4 Maintenance of Water-Based Fire sprinkler heads in rooms 7 and 8 and Protection Systems, Section 2-2.1.2 states cited NFPA 13, Section8-10.6.2.1.9* -2010 edition in relation to the unacceptable obstructions to spray blades of the ceiling fan. See patterns shall be corrected. NFPA 13, attached documentation. 1999 Edition Standard for the Installation If the ISDH does not agree with the of Sprinkler Systems, Table 5-6.5.1.2 resolution, ED will be responsible for states that distance between a sprinkler having Emcor Hyre Electric remove head an obstruction less than 1 foot away and cap the ceiling fans in Rooms 7 and 8 within 2 weeks of the cannot be lower than the sprinkler head determination. The ED is deflector. This deficient practice could responsible for compliance. 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. JT8I21

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	IT OF HEALTH AND HU! OR MEDICARE & MEDIC				PRINTED: 11/01/2 FORM APPROVED OMB NO. 0938-0391				
				X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLA	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING <u>02</u>			COMPLETED		
		151500	B. WI	B. WING			/2016		
	NAME OF PROVIDER OR SUPPLIER HOSPICE OF THE CALUMET AREA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUPERIOR AVE MUNSTER, IN 46321					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE		
	3.1-19(b)								

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