STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 01 B. WING	03/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

(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 and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/27/17 Facility Number: 011049 Provider Number: 155670 AIM Number: 200258520 At this Life Safety Code survey, Signature Healthcare of Newburgh was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 104 and had a census of 79 at the time of this	K 0000	K 000 The facility requests that this plan of correction be considered its credible allegation of compliance effective April 10, 2017. Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is submitted timely and in accordance with State and Federal Regulatory Guidelines. Any additional documents can be made available for your review. If you have any questions, please feel free to contract me at 812-473-4761. Respectfully, Joe Gamble, HFA, CEO.	

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

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	survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/30/17 - DA			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 10 hazardous areas, such as a housekeeping storage room, was provided with a self closing device. This deficient practice could affect residents, as well as staff and visitors while in the front entrance smoke barrier which includes the Beauty Shop, Dining Room and Activity Room, as well as staff offices. Findings include: Based on observation on 03/27/17 at 12:17 p.m. during a tour of the facility with the Director of Plant Operations, the corridor door to the housekeeping storage room was not provided with a self closer. The housekeeping storage room was full of cardboard boxes, cleaning chemicals and other storage items. This was acknowledged by the Director of Plant Operations at the time of observation. 3.1-19(b)	K 0321	K321 It is the intent of this facility to ensure that hazardous areas are protected by self-closing doors. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -Self-closure mechanism has been installed on the corridor door to the housekeeping storage room that was identified. 2.How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? ·All other areas were inspected and no others were found that need self-closure mechanisms. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? ·All doors will be checked during monthly safety rounds to ensure that this does not recur. 1.By what date the systematic changes will be completed?	04/10/2017

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			·April 10. 2017	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure documentation was complete to show all facility smoke detectors were within their listed and marked sensitivity range. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has 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	K 0345	K 345 It is the intent of this facility to ensure that all fire alarm maintenance and testing meets the standards. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - The testing conducted by FESCO on 8/25/2015 was complete, including sensitivity testing, but was not input correctly . FESCO has provided the correct report and a letter to verify that this was the case. -Testing was completed on all Duct Detectors on 1/15/2017 by FESCO and the report is documented by FESCO. - Maintenance Manager of the facility has been inserviced by the	04/10/2017

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	alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include:		Regional Plant Operations manager as to what must be included in reports from vendors in the future. 2. How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? - All residents had potential to be effected, but as above it was a reporting issue by the vendor and not a failure to inspect. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? - Maintenance Manager of the facility has been inserviced by the Regional Plant Operations manager as to what must be included in reports from vendors in the future. 4. By what date the systematic changes will be completed? - April 10. 2017	

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	Based on record review on 03/27/17 at 9:40 a.m. with the Director of Plant Operations present, there was documentation all 134 hardwired smoke detector were tested for sensitivity on 08/14/15. The report listed the sensitivity range for all smoke detectors and also a "pass" result for all smoke detectors, however, the report did not provide a "read sensitivity" (alarm point) for each smoke detector. This was acknowledged by the Director of Plant Operations at the time of record review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of 3 of 134 smoke detectors was complete. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, at 7.3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies, which requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all resident, staff and visitor in the facility. Findings include:			

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	Based on record review on 03/27/17 at 9:51 a.m. with the Director of Plant Operations present, the most recent smoke detector sensitivity test report dated 08/14/15 indicated that 134 total smoke detectors were tested, however, during the most recent annual fire alarm system inspection conducted on 08/29/16 there were only 131 smoke detector inspected/tested visually and functionally. Three of eight duct smoke detectors were not tested during the annual inspection on 08/29/16. Based on interview at the time of record review, the Director of Plant Operations acknowledged the lack of documentation to show the three duct smoke detectors were inspected/tested on the 08/29/16 annual fire alarm inspection report. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview,	K 0346	K 346	04/10/2017

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	the facility failed to provide a complete written policy for the protection of 79 of 79 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 03/27/17 at 11:45 a.m. with the Director of Plant Operations present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include contacting the Indiana State Department of Health (ISDH), plus phone number for the ISDH, local fire department, and the facility's insurance company. Furthermore, the fire watch policy did not include documentation of a walk through of the facility every fifteen minute, plus the only duty the fire watch person has is the fire watch. Based on an interview at the time of record review, the Director of Plant Operations acknowledged the lack of information in the fire watch policy. 3.1-19(b)		It is the intent of this facility to ensure written policies are kept up to date in the facility Emergency Response Plan. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ·Emergency Response Plan books were updated to be building specific and include procedure for fire watch in the event that fire alarm system is out of service for more than 4 hours in a 24 hour period. These books are located on each nurses' station and in the administrator's office. The employees have been inserviced on the location and content of the books. 1.How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? ·All residents have the potential to be effected. Corrective actions noted in #1. 1.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? ·Emergency Response Plan books will be reviewed at Safety Committee at least annually.	

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			4. By what date the systematic changes will be completed? - April 10. 2017	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 2 of 2 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves	K 0353	New sprinkler heads ordered April 5, 2017. K 353 It is the intent of this facility to ensure sprinkler maintenance and testing is done according to standards. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	04/05/2017

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	and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 03/27/17 at 11:00 a.m. with the Director of Plant Operations present, there was documentation available from Safe Care that quarterly sprinkler inspections were performed on 04/29/16, 07/21/16, 10/19/16 and 01/23/17. Weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review. Furthermore, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Director of Plant Operations		- Sprinkler system valves and gauges are now checked weekly and recorded - Sprinkler heads were inspected and while 1 sprinkler head was cited for corrosion in the kitchen dishwashing room, 17 sprinkler heads have been measured, ordered and will be replaced by SafeCare. This includes the sprinkler head that was cited. In addition, 25 escutcheons have been measured and ordered on April 5, 2017. It will take 3 to 4 weeks for these materials to be received, but will be installed as soon as received. 2. How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? - All residents have the potential to be effected. Corrective action as in #1. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? - Sprinkler heads will be checked during maintenance rounds. 4. By what date the systematic changes will be completed? - April 5. 2017 new sprinkler heads	

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	indicated the facility performs regular visual sprinkler system inspections but does not document sprinkler system gauge and system control valves inspections and acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. Based on observations with the Director of Plant Operations during a tour of the facility from 11:55 a.m. to 2:00 p.m. the facility has a total of nine pressure gauges at the sprinkler riser. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect mostly kitchen staff. Findings include: Based on observation on 03/27/17 at 12:50 p.m. during a tour of the facility		ordered (17). Will be received in 3 to 4 weeks and installed.	

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	with the Director of Plant Operations, there was one sprinkler head in the kitchen dishwashing room covered with corrosion. This was acknowledged by the Director of Plant Operations at the time of observation. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 79 of 79 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply	K 0354	K 354 It is the intent of this facility to ensure that the Emergency Response plan and policies/procedures meet the required standard. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	04/10/2017

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	with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 03/27/17 at 11:45 a.m. with the Director of Plant Operations present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include contacting the Indiana State Department of Health (ISDH), plus phone number for the ISDH, local fire department, and the facility's insurance company. Furthermore, the fire watch policy did not include documentation of a walk through of the facility every fifteen minute, plus the only duty the fire watch person has is the fire watch. Based on an interview at the time of record review, the Director of Plant Operations acknowledged the lack of information in the fire watch policy. 3.1-19(b)		- The Emergency Response Plan and the accompanying policies/procedures have been updated to meet the standard. 2. How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? - All residents have the potential to be effected. Corrective action as in #1. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? - All Emergency Response Plan books have been updated tp ensure the standard is being met. These books are located on each nurses' station and in the administrator's office. The employees have been inserviced on the location and content of the books. 4. By what date the systematic changes will be completed? - April 10, 2017	
K 0711 SS=F	NFPA 101 Evacuation and Relocation Plan			

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SIGNATURE HEALTHCARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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Bldg. 01	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 79 of 79 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. 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 fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 0711	K 711 It is the intent of this facility to ensure that the Emergency Response plan includes an Evacuation and Relocation plan. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - The Emergency Response Plan and the accompanying policies/procedures have been updated to meet the standard. 2. How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? - All residents have the potential to be effected. Corrective action as in #1.	04/10/2017

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	155670	A. BUILDING 01 B. WING	03/27/2017

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	Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the Fire Discovery and Announcement plan on 03/27/17 at 11:35 a.m. with the Director of Plant Operations present, the available fire plan was a generic fire plan and was not building specific, furthermore, the plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned written fire safety plan was a generic plan and was not building		3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? - All Emergency Response Plan books have been updated tp ensure the standard is being met. These books are located on each nurses' station and in the administrator's office. The employees have been inserviced on the location and content of the books. 4. By what date the systematic changes will be completed? - April 10, 2017	

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	specific. Based on observations between 11:55 a.m. and 2:00 p.m. during a tour of the facility with the Director of Plant Operations, various wheeled carts and equipment were observed in corridors throughout the facility. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/27/17 at 10:45 a.m. with	K 0712	K 712 It is the intent of this facility to ensure that fire drills are conducted in a manner to meet the standard. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - The calendar of required drills by quarter will be reviewed	04/10/2017

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	the Director of Plant Operations present, the facility performed twelve fire drills during the past twelve months, however, the facility lacked fire drill documentation for the second shift (evening) and third shift (night) of the third quarter (July, August, and September) of 2016. This was confirmed by the Director of Plant Operations at the time of record review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 7 of 12 fire drills during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 03/27/17 at 10:45 a.m. with the Director of Plant Operations present, 4 of 4, third shift "simulated" fire drill reports plus, 3 of 8 first and second shift		with the Safety Committee and the QAPI Committee to ensure facility stays in compliance. In the event that there is a change in Maintenance Manager, drills will still be conducted as per standard. Administrator will utilize support from sister facilities maintenance departments to ensure the standard is met. 2. How will other residents having the potential to be effected by the same deficient practice be identified and what corrective actions will be taken? - All residents have the potential to be effected. Corrective action as in #1. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? - As in #1 4. By what date the systematic changes will be completed? - April 10, 2017	

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	fire drill reports (dated: 10/04/16, 01/16/17, and 02/28/17) did not include information of the transmission of the fire alarm to the monitor company. This was acknowledged by the Director of Plant Operations at the time of record review. 3-1.19(b)			