

LOOKING FOR A NURSING HOME FOR A LOVED ONE?

BETHLEHEM WOODS NURSING AND REHABILITATION CENTER



Address: 4430 Elsdale Drive
Phone: 485-8157
Owner: Health and Hospital Corp. of Marion County
Officers: Matthew Gutwein, Patricia Hebenstreit, Greg Porter and Daniel Sellers
Most recent change in ownership: Dec. 1, 2003; former owner Bethlehem Woods Nursing & Rehabilitation Center LLC
Status: For-profit
Administrator: Lodene Yaney
Hire date: Sept. 28, 2006
Beds: 90 Medicare/Medicaid certified
Census: 88 as of Aug. 15, 2006
Sprinkler system status: Full sprinkler system
Resident rooms with system-based smoke alarms: 46

Resident rooms with battery-operated smoke alarms: 1 Common areas with smoke alarms: 3 of 3, all system-based alarms

Most recent annual survey: Date: Aug. 18, 2006
In substantial compliance? No
When compliance met: Sept. 8, 2006

Deficiencies found in Levels D-L:** 7 D; 1 E; 2 G

D Level:
◆ Failure to date, label and dispose of items in a refrigerator on one hall, to maintain a clean freezer and repair a broken toilet paper holder. Muffins dated two months earlier were in the secured unit refrigerator, and undated eggs were in a storage bag; freezer needed defrosting. According to the report, a facility nurse consultant told surveyors the maintenance director throws away all work orders.

◆ Failure to do an accurate assessment of fall risks for two residents. A morbidly obese resident with cardiac and other medical problems fell June 25, 2006, while being transferred from bed to a wheelchair using a sliding board. She broke her leg, which required surgery. A June and July fall risk assessment rated her as not a high risk for falls; her

care plan called for a one-person assist for transferring from bed to chair. A nursing director told surveyors in August that the earlier assessments had not been scored properly and that since the fall, the resident needed three people to assist, one to hold the locked wheelchair and two to assist using the board.

Another resident with a history of dizziness and osteoporosis fell on her walker in early June 2006 when getting up to use the bathroom; she broke her arm. Surveyors could not find a completed fall risk assessment prior to her breaking her arm.

◆ Failure to follow doctor's orders dated July 5, 2006, to use a splint on a resident's hand. He was to wear it whenever he was in his wheelchair, but surveyors noted he did not wear it for the three days of the survey period. A nurse and a nursing assistant caring for him, as well as the assistant director of nursing, said on Aug. 17 that they did not know about the splint.

◆ Failure to follow care plans for another resident who was to wear a hand splint, except when eating and in bed. Surveyors noted she ate with the splint on, yet was seen propell-

ing herself down the hallway in her wheelchair without the splint.

◆ Failure to properly adjust a resident's wheelchair to ensure she was comfortable and positioned correctly. The resident had complained on multiple occasions about the discomfort, but she was unable to change the chair's position because she could not reach the levers. The woman filed a formal complaint regarding her discomfort but said the problem had not been solved. The therapy director told surveyors if the chair's latches were not correctly positioned, the back of the chair could fall off. NOTE: A complaint was filed and substantiated regarding this matter.

◆ Failure to ensure correct measures were followed to prevent pressure sores from developing on one resident's heels. A doctor had ordered a heel protector to be worn when the resident was in bed, but surveyors noted the protector boot was sitting in a wheelchair while the resident was in bed.

◆ Failure to properly dispose of garbage. Large garbage bins were left uncovered on three of five days during the survey period. Surveyors saw employees standing by exposed, filled garbage bags but walk-

ing away without picking up the trash. The facility's nurse consultant said Bethlehem Woods had no policy regarding trash.

E Level:
◆ Failure to maintain patient-care equipment in safe operating condition and to provide routine maintenance records for bed rails and bed wheel locks. This deficiency related to a resident who was cut by the sharp, uncovered end of her bed rail.

G Level:
◆ Failure to prevent an injury of a resident by keeping the environment free of hazards. She suffered a deep cut from a sharp edge on her bedside rail. The end cap was missing on the rail, exposing a sharp area that cut the woman as she was being transferred from wheelchair to bed; 21 stitches were required to close the wound. Maintenance was to do regular equipment repairs, but maintenance repair logs for June-August 2006 were blank. Surveyors were told by management staff that the maintenance director "throws all the work orders away," the report stated. Note: A complaint regarding this injury was filed and substantiated.

◆ Failure to provide supervision and assistive devices to prevent the fall of

the aforementioned resident who broke a leg when transferring from bed to wheelchair. A nursing assistant said she had not locked the bed wheels before attempting to transfer the 315-pound woman.

Substantiated complaints in 2006: 3
Previous year: None
Federal Quality Initiative scores: Staffing hours per resident per day for licensed nursing staff: Bethlehem Woods: 57 minutes
Statewide average: 1 hour, 24 minutes

National average: 1 hour, 12 minutes
For nursing assistants: Bethlehem Woods: 1 hour, 54 minutes
State average: 2 hours
National average: 2 hours, 18 minutes

National Nursing Home Compare Score (based on three years of data): (the lower the score, the better)
Bethlehem Woods: 226
Statewide Average: 165
State licensure actions this quarter: None
Federal actions imposed: None

LIFE CARE CENTER OF FORT WAYNE



Address: 1649 Spy Run Ave.
Phone: 422-8520
Owner: Life Care Centers of America Inc., Cleveland, Tenn.
Officers: Forrest Preston, Angelena Clayton, J. Stephen Ziegler and Cindy Cross
Most recent change in ownership: None
Status: For profit
Administrator: Phil R. Ford
Hire date: April 27, 2006
Beds: 125
Census: 77 as of Aug. 21, 2006
Sprinkler system status: Full sprinkler system

Resident rooms with single, battery-operated smoke alarms: 0
Resident rooms with system-based smoke alarms: 0
Common areas with smoke alarms: 5 out of 5, all system-based

Most recent annual survey: Date: Aug. 24, 2006
In substantial compliance? No
When compliance met: Oct. 13, 2006

Deficiencies found in Levels D-L:** 14 D; 6 E; 1 G

D Level:
◆ Failure to assess a resident for ability/willingness to self-administer inhaled medication; resident said he did not want to administer the inhaler himself, yet staff gave him the medication; he did not use it properly.

◆ Failure of a nursing assistant to provide privacy for incontinence care of a resident; state surveyors witnessed the nursing assistant grab a resident's covers and pull them down, exposing her. "The resident's eyes widened and she grabbed a hold of the top edge of the blanket," the surveyor reported. "The staff member did not speak to the resident except to say, 'Let go, let

go.'" The resident was left for a time in full view of a roommate and surveyor, with no top, pants or blankets on.

◆ Failure to ensure three residents could reach their call lights; one resident had multiple medical needs and required extensive help to get from bed to chair and for dressing, hygiene and bathing. Surveyors heard her calling out for help. In another case, a resident with a tracheotomy – a breathing tube implanted into the trachea – was observed with dried blood on his gown and under several fingernails. "A gurgling sound was heard as the resident inhaled and exhaled," yet his call light was unreachable, the report stated.

One resident told surveyors she waits 45 minutes to an hour for staff to respond to her call light when needing the bedpan. She said staff tell her they will return after picking up meal trays, but told surveyors she has looked out her window to see her caregivers "walking across the street to (an unnamed business)," the report stated.

◆ Failure to provide activities to meet three residents' interests or needs or to provide transportation to such activities. Two residents requested in-room activities. One has vision problems, and his care plan called for volunteers or staff to assist with letter writing and other activities, but surveyors observed him spending multiple hours alone in his room. "Staff did not engage the resident in conversation nor provide materials or interventions for an individualized activity program," the report stated.

Another resident, who was bedfast, was to spend one-third to two-thirds of her time in activities, yet surveyors said the resident did not have a radio or TV in her room. "Staff did not provide nor encourage her participation in an individualized activity program in her room during all observation periods."

The third resident was observed for multiple hours over three days "lying in bed, on her back with eyes closed." No staff members were seen entering the room during the observed periods. The activities director said she didn't take the

resident to music activities "because she can hear (the music from her room.)" Yet the resident's care plan said she enjoyed cards, games, music, watching TV and talking with others.

◆ Failure to do quarterly assessments for a resident with brain injury who was prone to wander and leave the facility. In March 2005, the clinical assessment stated the resident was bedfast and not prone to wander; yet in August 2006, the resident had three incidents of wandering away in a wheelchair.

◆ Failure to document assessment of placements and replacements of feeding tubes; in one case, a non-working feeding tube was pulled out by a nurse but part of the tube was "lost," likely left in the stomach. A surgical procedure to scope the resident's stomach and intestine was unsuccessful in finding the lost part. Yet surveyors found no further documentation that the resident was assessed later for signs of a foreign object internally.

◆ Failure to follow care plans of two residents. One resident was to have bed safety rails, as ordered by her doctor; another resident was to have oxygen via a tube in the nose at all times. Surveyors observed on multiple occasions the rails down and the oxygen not in use.

◆ Failure to supervise and assist a resident with eating; the resident had difficulty swallowing and was at risk for aspirating food, but staff delivered his meal tray to his room and left. He ate less than half of the meals, said surveyors, who also noted over a three-day period, they did not see staff comb the hair of another resident who was totally dependent on hygiene and grooming assistance.

◆ Failure to turn a resident with pressure sores every two hours, as called for in the care plan.

◆ Failure to follow prepared menu instructions for 11 residents. In some cases, residents were not given the choices they had ordered. For example: Menu choices included frosted gelatin for one meal, but the residents were given a bowl of red, liquefied syrup which they could not eat with a spoon. The dietary manager admitted menus given to

residents did not match menus made by the dietician. Six residents told surveyors food was of poor quality and overcooked.

◆ Failure to provide foods that were attractive and palatable.

◆ Failure to provide substitute menu items to residents who said they had chosen alternatives to the main menu items. Multiple residents, for example, said they did not want collard greens, but staff would not get them a different vegetable.

◆ Failure to store, prepare and serve food under sanitary conditions: food on the kitchen floor; grease/dirt on steam table; food on kitchen baseboards; improper water temperature where staff washes hands; trash can inaccessible so staff recontaminated their hands after washing them by lifting the lids on garbage barrels to discard paper towels; dirty mixer, toaster, knife rack, trays and other kitchen items; undated meat and cheese packages open in the cooler; dietary staff touched their uniforms, hair, faces and soiled dishes while filling plates of food; flies landed in macaroni salad, which was later served to residents.

◆ Facility staff failed to use accepted professional practice for hand washing after direct contact with residents.

E Level:
◆ Failure to thoroughly investigate, according to federal/state laws and facility policies, two of six incidents of resident injury to ensure abuse was not involved. The injuries included a broken arm of one resident and a cut requiring stitches in another resident. Although the facility had assessed the residents as high risk of falls, in the first situation, there was no written investigation of the location of the fall, what adaptive devices the woman used, her medication or environmental factors.

Regarding the resident who required stitches, the facility also failed to record the conditions listed above or to look at trends in falls, including witnesses, staff involved and other criteria. Facility policy calls for an appointment of a resident representative to investigate the incident and interview staff members.

1D; 1E;

D Level:

◆ Failure to ensure hot-water temperature on one hall was within safe parameters; water temperature was 128.2 degrees during survey and had reached 130 on one day prior to inspection. Safe levels are 105-120 degrees. There was no record of what was done to correct the problem when 130 degrees was found.

E Level:

◆ Four staff members were observed

incorrectly disinfecting tables and shower chairs; disinfectant is to be left on surfaces for 10 minutes before wiping off.

Substantiated complaints in 2006: 1
Previous year: None
Federal Quality Initiative scores: Staffing hours per resident per day for licensed nursing staff: Renaissance Village: 1 hour, 25 minutes
Statewide average: 1 hour, 24 minutes
National average: 1 hour, 12 minutes

National Nursing Home Compare Score (based on three years of data): (the lower the score the better)
Renaissance: 55
Statewide Average: 165
State licensure actions this quarter: None
Federal actions imposed: Federal civil penalty of \$150/day Aug. 24-Oct. 12, 2006

equipment in safe operating condition – ice machines were not in proper working condition to prevent contamination in the holding bin.

◆ Failure to maintain an effective pest-control program. A staff member said the facility had ongoing problems with mice. Several residents told surveyors they had seen mice more than once in the facility. Surveyors saw mouse traps in a dining room corner and in a food-storage room. One resident said a mouse was seen in one of the TV rooms almost daily. A pest-control company report showed 14 mice were removed from traps or caught in the facility between mid-March and mid-August.

G Level:
◆ Failure to do quarterly assessments regarding use of restraints and other measures to decrease risk of falls. This deficiency related, in part, to the incidents of the aforementioned residents who fell and suffered injuries requiring hospital treatment. One resident fell out of bed, receiving a nosebleed and bruises because the person's bed-alarm batteries were dead so the alarm never sounded. There was no documentation that bed-alarm batteries were checked regularly.

Substantiated complaints in 2006: None
Previous year: 5
Federal Quality Initiative scores: Staffing hours per resident per day for licensed nursing staff: Life Care Center: 1 hour, 26 minutes
Statewide average: 1 hour, 24 minutes
National average: 1 hour, 12 minutes

For nursing assistants: Life Care Center: 1 hour, 58 minutes
State average: 2 hours
National average: 2 hours, 18 minutes

National Nursing Home Compare Score (based on three years of data): (the lower the score the better)
Life Care Center: 323
Statewide Average: 165
State licensure actions this quarter: None
Federal actions imposed: Federal civil penalty of \$150/day Aug. 24-Oct. 12, 2006

RENAISSANCE VILLAGE



Address: 6050 S. County Road 800 E-92
Phone: 625-3545

Owner: Renaissance Health Care LLC, Fort Wayne

Officers: Michael Mohrman, Bill Ehinger and Gary Probst
Most recent change in ownership: Sept. 22, 1993; former owner Renaissance Health Care Corp.

Status: For profit
Administrator: Deborah I. Mills
Hire date: Jan. 1, 1998

Beds: 96; 64 are Medicaid, 32 are Medicare/Medicaid certified
Census: 83 as of Aug. 15, 2006
Sprinkler system status: Full

Resident rooms with system-based smoke alarms: Not available
Resident rooms with battery-operated smoke alarms: Not available
Common areas with smoke alarms: Not available

Most recent annual survey: Date: Aug. 18, 2006
In substantial compliance? No
When compliance met: Sept. 23, 2006

Deficiencies found in Levels D-L:**

D: Isolated/minimal harm or potential for actual harm – A less serious deficiency and isolated to the fewest number of individuals; results in minimal discomfort or has the potential to negatively affect a resident's ability to achieve his/her highest level of functioning.

E: Pattern/minimal harm or potential for actual harm – A less serious deficiency affecting more than a limited number of individuals; results

in minimal discomfort or has the potential to negatively affect residents.

F: Widespread/minimal harm or potential for actual harm – A less serious deficiency that is widespread; results in minimal discomfort or has the potential to negatively affect residents.

G: Isolated/actual harm – A more serious deficiency isolated to the fewest number of individuals;

negatively affects the resident's ability to achieve his/her highest functioning.

H. Pattern/actual harm – A more serious deficiency affecting more than a limited number of individuals; negatively affects residents.

I. Widespread/actual harm – A more serious deficiency that is widespread and/or has the potential to affect a large number of residents.

J. Isolated/immediate jeopardy – The

most serious deficiency, although isolated to the fewest number of residents, staff or occurrences; has caused or is likely to cause serious injury, harm, impairment or death; immediate corrective action required.

corrective action required.
L. Widespread/immediate jeopardy – the most serious deficiency and widespread throughout the facility; places residents in immediate jeopardy, causing or likely to cause serious injury, harm, impairment or death; immediate corrective action required.

Explanation

Nursing homes are given deficiencies according to ratings set by the federal government. Although there are A-C ratings, they are the least serious deficiencies and are not tracked in News-Sentinel reports. Levels D-L have the following meanings, with D being less severe and L indicating the most serious deficiency. Levels G-L are particularly cause for concern:

FROM THE FRONT PAGE/WORLD

TRANSITIONAL CARE UNIT OF ST. JOSEPH HOSPITAL

Address: 700 Broadway
Phone: 425-3940
Owner: St. Joseph Health System

LLC, Fort Wayne
Officers: James Shelton, Donald Fay, Robert Frutiger, Michael Silhol and Burke Whitman
Most recent change in ownership: July 1, 1998; former owner Ancilla Systems Inc.
Status: For profit
Administrator: Rebecca M. Henry
Hire date: Nov. 6, 1989
Beds: 21, Medicare certified only
Census: 15 as of Aug. 29, 2006
Sprinkler system status: Full sprinkler system
Resident rooms with smoke alarms:

21 of 21, all system-based
Common areas with smoke alarms: 3 of 3, all system-based
Most recent annual survey: Date: Aug. 30, 2006
In substantial compliance? No
When compliance met: Aug. 31, 2006
Deficiencies found in Levels D-L:** 3 E
E Level:
◆ Failure to follow facility policy and procedure for storing frozen food in three of seven freezers. Freezer temperatures ranged from

more than 20 degrees to 2 degrees; freezers are to remain between 0 degrees and 10 below 0 degrees Fahrenheit. Adequate records of daily freezer temperatures also were not kept.
Ice-machine drainage systems also were not working properly
◆ Nursing staff failed to properly disinfect shower chairs; disinfectant was to remain on surfaces for 10 minutes before wiping off.
◆ Failure to keep equipment in good repair and safe operational condition. This deficiency related to

the freezers.
Substantiated complaints in 2006: 0
Previous year: 0
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff (for hospital-based or Medicare-only nursing homes):
St. Joe TCU: 5 hours, 42 minutes
Statewide average: 4 hours
National average: 2 hours, 36 minutes
For nursing assistants:
St. Joe TCU: 20 minutes
State average: 2 hours, 36 minutes

National average: 2 hours, 36 minutes
National Nursing Home Compare Score (based on three years of data for hospital-based or Medicare-only nursing homes):
(the lower the score the better)
St. Joe TCU: 30
Statewide Average: 165
State licensure actions this quarter: None
Federal actions imposed: None

TOWNE HOUSE RETIREMENT COMMUNITY

Address: 2209 St. Joe Center Road
Phone: 483-3116
Owner: Baptist Homes of Indiana Inc., Zionsville
Officers: Richard Keenan, James McDaniel, Roger Miller,
Most recent change in ownership: None
Status: Nonprofit

Administrator: B. Daniel Carr
Hire date: Nov. 17, 1985
Beds: 107 nursing-home level care, with only six Medicare certified and inspected by both state and federal surveyors; none are Medicaid beds
Census: Four out of six beds, as of Sept. 19, 2006
Sprinkler system status: Full sprinkler system
Resident rooms with system-based smoke alarms: 0
Resident rooms with battery-operated smoke alarms: 0
Common areas with smoke alarms: 11 of 11, all system-based
Most recent annual survey: Date: Sept. 21, 2006
In substantial compliance? No
When compliance met: Oct. 28, 2006

Deficiencies found in Levels D-L:** 1 D; 3 G
D Level:
◆ Failure to notify the physician of the worsening of a resident's pressure sores. The resident had formerly lived in the residential area, where she fell and broke a hip in August 2006. After hospitalization for surgery, she returned to the nursing home wing of Towne House. On Aug. 7, an early-stage pressure sore on her left heel was documented. On Aug. 27, a nurse noted the sore was larger and the tissue had a black, semi-hard area. There was no documentation the doctor had been informed of the change until 15 days after the worsening condition was noted by nurses. Between Aug. 27 and Sept.

11, nursing staff made no changes in the way they tended to the wound.
G Level:
◆ Failure to complete a skin risk assessment in a timely manner for the aforementioned resident after she returned from the hospital. Nurses noted she had bruising on her arms and thigh, but no assessment of the woman's heels was documented. Federal guidelines for nursing homes show that pressure sores can develop within two-to-six hours of onset of pressure on an area.
◆ Failure to develop, review and revise the woman's care plan to prevent her from developing pressure sores after she was readmitted to the hospital.
◆ Failure to ensure a resident

without pressure sores did not develop them unless the person's clinical condition made development unavoidable; failure to ensure a resident with pressure sores received the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
Other:
◆ State findings that merited no deficiencies included: failure to ensure a dietary employee had completed the required testing for TB.
Substantiated complaints in 2006: 0
Previous year: 0
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff (for hospital-based or Medicare-only

nursing homes):
Towne House: Not available
Statewide average: 4 hours
National average: 2 hours, 36 minutes
For nursing assistants:
Towne House: Not available
State average: 2 hours, 36 minutes
National average: 2 hours, 36 minutes
National Nursing Home Compare Score (2006 was first year Towne House accepted Medicare residents):
(the lower the score the better)
Towne House: 189
Statewide Average: 165
State licensure actions this quarter: None
Federal actions imposed: None

Explanation

Nursing homes are given deficiencies according to ratings set by the federal government. Although there are A-C ratings, they are the least serious deficiencies and are not tracked in News-Sentinel reports. Levels D-L have the following meanings, with D being less severe and L indicating the most serious deficiency. Levels G-L are particularly cause for concern:

D: Isolated/minimal harm or potential for actual harm – A less serious deficiency and isolated to the fewest number of individuals; results in minimal discomfort or has the potential to negatively affect a resident's ability to achieve his or her highest level of functioning.
E: Pattern/minimal harm or potential for actual harm – A less serious deficiency affecting more than a limited number of individuals; results

in minimal discomfort or has the potential to negatively affect residents.
F: Widespread/minimal harm or potential for actual harm – A less serious deficiency that is widespread; results in minimal discomfort or has the potential to negatively affect residents.
G: Isolated/actual harm – A more serious deficiency isolated to the fewest number of individuals;

negatively affects the resident's ability to achieve his or her highest functioning.
H. Pattern/actual harm – A more serious deficiency affecting more than a limited number of individuals; negatively affects residents.
I. Widespread/actual harm – A more serious deficiency that is widespread and/or has the potential to affect a large number of residents.
J. Isolated/immediate jeopardy – The

most serious deficiency, although isolated to the fewest number of residents, staff or occurrences; has caused or is likely to cause serious injury, harm, impairment or death; immediate corrective action required.
K. Pattern/immediate jeopardy – The most serious deficiency affecting more than a limited number of individuals; has caused or is likely to cause serious injury, harm, impairment or death; immediate

corrective action required.
L. Widespread/immediate jeopardy – the most serious deficiency and widespread throughout the facility; places residents in immediate jeopardy, causing or likely to cause serious injury, harm, impairment or death; immediate corrective action required.

REFORM: Bills call for safety changes

Continued from Page 1A

Indiana State Department of Health.

In October, the federal Centers for Medicare and Medicaid Services, or CMS, published proposed regulations requiring sprinkler systems for nursing homes receiving Medicare and Medicaid payments. A comment period on the proposal ended in late December, but it has not yet been finalized.

Nursing homes built before 1968 have been exempt from having sprinkler systems; those built afterward or that have expanded since then must have sprinkler systems throughout or in the new area.

Grant has strong hopes a sprinkler-system bill will finally become law. The Indiana Association of Homes and Services for the Aging and Indiana Health Care Association, nursing home industry trade groups, support the legislation, with the caveat that facilities receive adequate time and money to comply.

The Indiana Family and Social Services Administration has a pool of money to fund the measure, made available through the state's quality assessment tax on nursing homes. A portion of those funds could be distributed in the form of grants for some of the state's 27 facilities with no system or only a partial one, said Steve Smith, director of the state's Division of Aging.

More smoke alarms needed

In November, a faulty lamp cord started a fire in a Floyd County nursing home resident's room. Flames spread to a chair and bed. A woman who lived in the room suffered burns to her hands and smoke inhalation. Yet two sprinklers in the room did not go off because the fire didn't generate enough heat, the New Albany fire chief told the Louisville (Kentucky) Courier-Journal.

Sixteen employees, including four who were treated at a hospital, also suffered smoke inhalation.

In May 2006, CMS approved federal nursing home regulations requiring, minimally, battery-operated smoke alarms in resident rooms in facilities without full sprinkler systems. Indiana building code only requires a smoke alarm in common areas, but the federal regulation now supersedes it.

In December, officials from the National Citizens' Coalition for Nursing Home Reform testified before CMS regarding fire-safety issues in nursing homes:

Information

For a listing of Indiana nursing homes and whether they have sprinkler systems and smoke detectors, visit www.isdh/regsvcs/ltr/repcard. Go to "Nursing Home Report Cards," then "View Nursing Home Report Cards." Identify the facility's city or county, then search for the name. The sprinkler/smoke detector data can be found on the Consumer Report.

"The occurrence of 2,300 structural fires in long-term care facilities each year is alarming, particularly as they occur in combination with chronic, epidemic rates of low staffing and staff turnover," testified Alice Hedt, the coalition's executive director.

It is asking CMS to require nursing homes to have full sprinkler systems within 18 months of the new regulations now being finalized.

Two bills circulating through the General Assembly carry compliance dates of July 1, 2012, Sen. Gary Dillon, R-Columbia City, who serves on the Senate Health and Provider Services Committee, said facilities need the extra time. The committee has approved the bill with amendments, and it will now go before the Senate for a second reading.

If CMS' compliance date comes sooner, that would supersede the date in the legislation but only for homes receiving Medicaid and Medicare payments.

Senate Bill 93 also calls for smoke detectors throughout every facility by July 1, 2012, but not in every resident's room, Dillon said. "I think they should have them, but I thought at the very least, people should know if they don't have them."

House Bill 1243 does not address smoke detectors. The proposed legislation was approved by the House Public Policy Committee but has not yet had a second reading in the House. Marlin Stutzman, R-Howe, a member of the committee, said the bill may need to be amended to add smoke-detector requirements.

"If people are going to put loved ones in these homes, it needs to be required. It only makes sense," he said.

United Senior Action is lobbying for nursing home smoke detectors to be hard-wired, not battery-operated. "The data show the hard-wired are much more dependable. Nurses can hear the detector go off from the nurses station and can get to the room sooner," Grant said.

A look at safety in nursing facilities

Proposed legislation in the State House and Senate calls for all Indiana nursing homes to install full sprinkler systems by 2012; Senate Bill 93 also would stipulate nursing homes to have a smoke-detection system throughout. The Indiana State Department of Health would be required to publish the status and types of sprinkler systems and smoke detectors in the department's Consumer Guide to Nursing Homes under SB93 and House Bill 1243. Although not yet mandated to do so, the health department in January began publishing data on nursing homes' sprinkler- and smoke-detection systems. Not all facilities submitted reports. Here's how Allen County nursing homes measure up at present:

FORT WAYNE FACILITIES

◆ Facility name
◆ sprinkler system
◆ smoke alarms/type in resident rooms
◆ commons area smoke alarms

Bethlehem Woods

◆ Full system
◆ 46 rooms system-based
◆ 1 battery-operated
◆ 3 of 3 areas system-based

Byron Health Center

◆ Full system
◆ N/A
◆ N/A

Canterbury Nursing & Rehabilitation

◆ Full system
◆ N/A
◆ N/A

Covington Manor

◆ Full system
◆ 0 alarms in 67 rooms
◆ 5 of 5 areas system-based*

Englewood Health & Rehabilitation

◆ Full system
◆ 0 of 27 rooms
◆ 8 of 8 areas system-based

Glenbrook Rehabilitation & Skilled Nursing Center

◆ Full system
◆ 1 of 77 rooms battery-operated
◆ 0 system-based
◆ 3 of 3 areas system-based

Golden Years Homestead

◆ Full system
◆ 3 of 55 rooms battery-operated
◆ 0 rooms system-based
◆ 5 of 13 areas system-based
◆ 0 battery-operated

Heritage Park

◆ Full system
◆ N/A
◆ N/A

Kingston Care Center

◆ Full system
◆ N/A
◆ N/A

Life Care Center

◆ Full system
◆ 0 of 68 rooms system-wide or battery-operated
◆ 5 of 5 system-based

Lutheran Home

◆ Partial system
◆ N/A
◆ N/A

Miller's Merry Manor

◆ Full system
◆ N/A
◆ N/A

Parkview Hospital Continuing Care Unit

◆ Full system
◆ 28 of 28 rooms system-based
◆ 2 of 2 areas system-based

Regency Place

◆ Full system
◆ 80 of 80 rooms system-based
◆ 8 of 8 areas system-based

Renaissance Village

◆ Full system
◆ N/A
◆ N/A

Riverbend Health Care Center

◆ Full system
◆ 0 of 40 rooms battery-operated or system-based
◆ 5 of 5 areas system-based

St. Anne Home

◆ Full system
◆ 0 of 103 rooms battery-operated or system-based
◆ 12 of 12 areas system-based

St. Joe Transitional Care Unit

◆ Full system
◆ 21 or 21 rooms system-based
◆ 3 of 3 areas system-based

Towne House

◆ Full system
◆ 0 of 58 rooms battery-operated or system-based
◆ 11 of 11 areas system-based

University Park

◆ Full system
◆ N/A
◆ N/A

Waters of Summit City (formerly Beverly)

◆ Full system
◆ N/A
◆ N/A

Woodview Healthcare

◆ Full system
◆ N/A
◆ N/A

OTHER ALLEN COUNTY FACILITIES**Harborside Healthcare, New Haven**

◆ Full system
◆ N/A
◆ N/A

The Cedars, Leo

◆ Full system
◆ N/A
◆ N/A

The Village of Heritage, Monroeville

◆ Full system
◆ 34 of 34 rooms system-based
◆ 8 of 8 areas system-based

Source: Indiana State Department of Health

Countries support pollution monitoring

A recently-released study appeals for a world-wide environmental regulatory body.

By ANGELA CHARLTON
of The Associated Press

PARIS — Fear of runaway global warming pushed 46 countries to line up Saturday behind France's appeal for a new environmental body that could single out — and perhaps police — nations that abuse the Earth.

"It is our responsibility. The future of humanity demands it," President Jacques Chirac said in an appeal to put the environment at the top of the world's agenda.

He spoke at a conference a day after the release in Paris of a grim report from the world's leading climate scientists and government officials that said global warming is so severe that it will "continue for centuries" and that humans are to blame.

The Intergovernmental Panel on Climate Change's report sparked calls for fast, planet-wide action and was embraced by Europeans. A total of 46 countries agreed to pursue plans for the new organization, and to hold their first meeting in Morocco this spring.

But key world polluters — including the United States, China, India and Russia — steered clear.

Without naming the United States directly, Chirac expressed frustration that "some large countries, large rich countries, still must be convinced." They are "refusing to accept the consequences of their acts," he said.

Chirac, 74, is seeking to leave his mark on international affairs before he leaves office, likely in May, though his environmental record over 12 years as France's president is spotty.

Former Vice President Al Gore, whose documentary on the perils of global warming has garnered worldwide attention, cheered Chirac's efforts.

"We are at a tipping point," Gore said in recorded remarks shown at the conference. Friday's report was "yet another warning about the dangers we face. We must act, and act swiftly. ... Such action requires international cooperation."

Many questions remain about the proposed environment body, including whether it would have the power to enforce global climate accords.

Chirac's appeal says only that the body should "evaluate ecological damage" and "support the implementation of environmental decisions."

Many countries have failed to meet targets for cutting greenhouse gas emissions laid out in the 1997 Kyoto Protocol. The United States has never ratified the pact.

In a published interview earlier this week, Chirac warned that the United States could face a carbon tax on its exports if it does not sign global climate accords.

"We have 700 multilateral environmental agreements, and none of them seem to work. Environmental institutions are extremely weak," said Cristian Maquieira, a Chilean government environment official, said,

Russian Deputy Foreign Minister Andrei Denisov said creating a new environment organization would require too much time and money. Instead, he urged expanding the powers of the existing U.N. Environment Program.

Several participants called for taxing actions that hurt the environment, or labeling products according to how ecologically clean they are.

U.S. economist Jeremy Rifkin urged governments, businesses and activists to work together to create a "post-carbon" era.

"Climate change is going to be more responsible for bringing about a borderless world than free trade," Rifkin said.