

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2014
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NAME OF PROVIDER OR SUPPLIER  PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
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K010000	<p>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).</p> <p>Survey Date: 07/10/14</p> <p>Facility Number: 000532 Provider Number: 155527 AIM Number: 100267180</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pineknoll Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in</p>	K010000	<p>Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010018 SS=E	<p>all resident sleeping rooms. The facility has a capacity of 58 and had a census of 45 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled with the exception of a detached wooden storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Therapy room and 1 of 1 storage room corridor doors closed and latched into the door frame. This deficient practice could affect 2 of 4 smoke compartments.</p> <p>Findings includes:</p> <p>Based on observation with the Maintenance Supervisor, the Administrator and the Administrator in Training on 07/10/14 at 12:40 and then again at 1:00 p.m., the Therapy room and the resident storage room were designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010018	<p>Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p> <p>1&amp; 2. No Residents were affected but all residents had the potential to be affected. The facility has removed the manual latching devices on the double corridor doors in the therapy room and storage room and will add a vertical rod exit device on both double doors.</p> <p>3. The Maintenance director was re-educated on locking devices on corridor doors (see attachment A). A new preventive maintenance monitoring form has been initiated. ( see attachment A1, A2)</p> <p>4. The Maintenance director or designee will be responsible for ensuring completing the preventive maintenance monitoring form to include checking all corridor doors weekly. The results of these reviews will be discussed during the facility's QA meetings for a minimum of 6 months and the plan adjusted accordingly.</p>	08/08/2014			

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K010025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire or conduit through 3 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all smoke barrier walls and therefore all occupants.</p> <p>Findings include:</p>	K010025	<p>Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p> <p>1 &amp; 2. No Residents were affected but all residents had the potential to be affected. Each unsealed penetrations above drop down ceiling tiles at all smoke barrier doors were sealed.</p> <p>3. The maintenance director was re-educated on sealing penetrations (see attachment B). A new preventative maintenance form has been initiated (see attachment B1, A2).</p>	07/11/2014

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K010027 SS=E	<p>Based on observations with Maintenance Supervisor on 07/10/14 from 2:00 p.m. to 2:20 p.m., at the following smoke barrier walls above the drop down ceiling tiles there were unsealed penetrations:</p> <p>a. above the smoke barrier doors in the service hall near the main dining room there was an unsealed penetration measuring one inch around an electrical wire</p> <p>b. above the smoke barrier doors in the east 100 hall there was an unsealed penetration measuring one fourth inch around a thermostat wire</p> <p>c. above the smoke barrier doors in the west 200 hall there was an unsealed penetration measuring one inch around the main sprinkler line.</p> <p>Measurements were provided by the Maintenance Supervisor at the time of observations and the smoke barrier wall penetrations were also acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the</p>		<p>4. The Maintenance director or designee will be responsible for completing the preventative maintenance form weekly to ensure all penetrations are sealed. The results of these reviews will be discussed during the facility's QA meetings for a minimum of 6 months and the plan adjusted accordingly.</p>	

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	<p>door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 2 of 4 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Supervisor, the Administrator and the Administrator in Training on 09/10/14 at 1:25 p.m., the smoke barrier doors in the service hall near the main dining room had a one half inch gap between the doors when closed. Based on an interview with the Maintenance Supervisor at the time of observation, he thought the self closing device needed to be adjusted.</p> <p>3.1-19(b)</p>	K010027	<p>Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance. 1&amp; 2. No Residents were affected but all residents had the potential to be affected. The facility has removed the corner door cover that prohibited the smoke barrier door from closing properly. 3. The maintenance director was re-educated on closer of smoke barrier doors (see attachment C). A new preventive maintenance form has been implemented (see attachment B1, A2). 4. The Maintenance director or designee will be responsible completing the preventative maintenance form on a weekly basis to ensure smoke barrier doors close properly. The results of these reviews will be discussed during the facility's QA meetings for a minimum of 6 months and the plan adjusted accordingly.</p>	07/11/2014

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect residents in</p>	K010143	Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance.1& 2. No Residents were affected but all residents had the potential to be affected. The facility has removed	07/22/2014

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K010144 SS=C	<p>1 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, the Administrator and the Administrator in Training on 07/10/14 at 1:10 p.m., the oxygen transferring room had two large liquid oxygen storage tanks placed in the room with one electrical receptacles on the wall forty two inches above the floor. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving</p>	K010144	<p>the outlet in the oxygen room. 3. The maintenance director was re-educated on outlet location in oxygen room (see attachment D). A new preventive maintenance monitoring form has been initiated (See attachment B1, A2). 4. The Maintenance director or designee will be responsible for ensuring oxygen room has no outlets with in 5 feet of the floor. The maintenance director will be responsible for completing the preventive maintenance form weekly. The results of these reviews will be discussed during the facility's QA meetings and for a minimum of 6 months the plan adjusted accordingly.</p> <p>Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts</p>	07/14/2014

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	<p>the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Equipment Record" with the Maintenance Supervisor, Administrator and Administrator in Training on 07/10/14 at 11:55 a.m., the documentation for the monthly generator load test did not include the amps and voltage for each phase of the generator so the percentage of the load could not be calculated and verified. This was confirmed by the Maintenance Supervisor at the time of record review.</p>		<p>alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance. 1&amp; 2. No Residents were affected but all residents had the potential to be affected. The facility implemented a new generator log form to include the generator amps and volts during each test run. (see attachment E1). 3. The maintenance director was re-educated on generator log documentation. A new generator monthly testing form has been implemented (see attachment E, E2). 4. The Maintenance director or designee will be responsible for completing the generator log form on a monthly basis to ensure generator running properly. The results of these reviews will be discussed during the facility's QA meetings for a minimum of 6 months and the plan adjusted accordingly.</p>				

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	3.1-19(b)				