STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENSSELAER CARE CENTER	1309 E GRACE ST RENSSELAER, IN 47978

(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: 01/19/16 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Life Safety Code survey, Rensselaer Care Center 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. This facility and it's additions were built prior to March 1, 2003, therefore they were surveyed in accordance with LSC Chapter 19. The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are	K 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly appliedImmediateThis facility respectfully request paper compliance.	

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

Any defiencystatement 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.

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	equipped with battery powered smoke detectors. The facility has the capacity for 157 and had a census of 89 at the time of this survey. All areas where residents have customary access were sprinklered. Two detached sheds for general storage were not sprinklered. Quality Review completed on 01/22/16 - DA			
K 0018 SS=D Bldg. 01	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 85 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 3 residents. Findings include:	K 0018	Immediate - Room 414 and 417 had the doors repaired by maintenance on 1.26.16 All others – Facility audit of door closures was completed by Maintenance prior to date of compliance Systemic – Maintenance department reviewed K tag 018	02/18/2016

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	Based on observation and interview on 01/19/16 at 11:01 a.m. then again at 11:02 a.m., the Maintenance Supervisor and Director of Nursing acknowledged the corridor door to resident room 414 and 417 failed to latch into the door frame when tested. 3.1-19(b)		prior to date of compliance. Audits – Facility will audit 1 hall per week X 4 weeks. Then 1 hall per month X 3 months and then quarterly until 95% compliance is achieved. Findings will be reviewed in PI meeting.	
K 0025 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 4 of 5 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and at least 64 residents.	K 0025	Immediate - All areas were repaired on 1.22.16 by maintenance. This is to include both smoke and fire barriers. All others – Facility audit was conducted by Maintenance to identify any other areas prior to date of compliance. Systemic – Maintenance department reviewed K tag 025 prior to date of compliance. Audits – Maintenance to audit affected areas 1 X per week x 4 weeks. 1 X per month X 3 months	02/18/2016

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	Findings include: Based on observations with the Maintenance Supervisor and Director of Nursing on 01/19/16 from 11:27 a.m. to 2:26 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted: a) the attic access panel was stuck open in the Main Computer Switch room. b) two separate three quarter inch penetrations in the smoke barrier by resident room 401 above the drop ceiling. c) one inch by one and a half inch penetration in the 100 East Hall smoke barrier above the drop ceiling. d) two separate two and a half inch penetrations in the smoke barrier by resident room 200 above the drop ceiling. e) three penetrations ranging from a half an inch to three quarter inch in the smoke barrier by resident room 215 above the drop ceiling. Based on interview at the time of each observation, the Maintenance Supervisor and Director of Nursing acknowledged and provided the measurements for each unsealed penetration. 3.1-19(b)		and then quarterly until 95% compliance is achieved. Findings will be reviewed in PI meeting.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾			

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	hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 Kitchen, 1 of 1 Laundry, and 4 of 4 storage rooms greater than 50 square feet, all hazardous areas, were provided with a self-closer and would latch into the frame. This deficient practice could affect staff and at least 25 residents. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 between 11:07 a.m. and 1:23 p.m. the following was discovered: a) At least 30 cardboard boxes were stored in the Accounts Payable Storage without a self-closing device. b) At least 30 cardboard boxes were stored in the Office Supply Room that failed to latch when tested. c) The South Housekeeping Soiled Linen room contained a 44 gallon container of	K 0029	K 029 Immediate – All Doors were repaired or had self-closures placed on them by maintenance prior to date of compliance. The therapy gym had their trash and soiled clothes bins changed to 10 gallon receptacles. All others – Facility audit of door closures was completed by Maintenance prior to date of compliance. Systemic - Maintenance department reviewed K tag 029 prior to date of compliance. Audits - Facility will audit 1 hall per week, appropriate door closures, X 4 weeks. Then 1 hall per month X 3 months and then quarterly until 95% compliance is achieved. Findings will be reviewed in PI meeting.	02/18/2016

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	soiled linen. When the door was released, the self-closer kept the door in the open position. d) At least 30 cardboard boxes were stored in the Central Supply South Hall. When the door was released, the bottom of the floor caught on the carpet and remained in the open position. e) One of two Laundry doors failed to latch into the frame when tested. f) One of four Kitchen doors failed to latch in the frame when tested. g) One 20 gallon container of trash was next to one 18 gallon container of soiled linen in Therapy. Neither of the two Therapy doors had a self-closer installed. Based on interview at the time each observation, the Maintenance Supervisor and Director of Nursing acknowledged each aforementioned condition. 3.1-19(b)			
K 0045 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide exterior	K 0045	K 045 Immediate – All noted areas had illumination corrected by the	02/18/2016

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	emergency lighting for 5 of 10 exterior exit discharge paths. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect staff and at least 44 residents. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 between 11:09 a.m. and 1:51 p.m., the following exit lights were tested and failed to illuminate: a) 400 Wing exterior lights. b) Patio exit exterior lights. c) South and North 200 Wing exterior lights d) North Dining Room exterior lights. Based on interview at the time of each observation, the Maintenance Supervisor and Director of Nursing acknowledged each aforementioned condition. 3.1-19(b)		maintenance department on 2.5.16. All others – All means of egress exit areas were reviewed by maintenance department prior to date of compliance Systemic – Maintenance department reviewed K tag 045 prior to date of compliance. Audits – Mentioned areas will be tested 1 X per week X 4 weeks, 1 X per month X 3 months and then quarterly until 95% compliance is achieved. Any negative findings will be reviewed in PI meeting. Maintenance or designee will complete the audits.	
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview;	K 0046	K 046 Immediate – Maintenance director performed a 30 second	02/18/2016

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	the facility failed to ensure 14 of 14 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility. Findings include: Based on record review with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 10:02 a.m., the facility provided the annual test, however, based on interview at the time of record review, the Maintenance Supervisor confirmed that the monthly testing was just "a quick press of the button" and not the required 30 seconds. 3.1-19(b)		test on all battery backup lights and necessary repairs were made prior to date of compliance. All others – 100% audit was conducted of all lights that have a battery back up by maintenance prior to date of compliance. Systemic – maintenance department reviewed K tag 046 prior to date of compliance. Audits – a 30 second test will be performed and documented by the maintenance department 1 X per month X 6 months. Any negative findings will be reviewed in PI meeting and Preventative Maintenance schedule will be followed.	

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K 0048 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation, and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review and observation on 01/19/16 between 10:08 a.m. and 2:32 p.m., the facility had a written fire policy that horizontal evacuation would be	K 0048	K 048 Immediate – Door casings were marked as "smoke barrier door" thus putting our fire exit strategy in compliance. All others – All doors were labeled as either smoke barrier or fire doors prior to date of compliance. Systemic – Maintenance reviewed K tag 048 prior to date of compliance. Audits – Doors will be reviewed monthly to ensure appropriate signage matches our exit strategy X 6 months.	02/18/2016

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	performed by crossing a fire barrier. However, there were three sets of doors that were not complete fire barriers, which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the	K 0050	K 050 Immediate – Maintenance director reviewed K tag 050 and reported that he does call to verify but failed to document the time and who he spoke with. This will now be documented. All others – Documentation of fire drills will include time of alarm along with who was spoken to at the monitoring company. Systemic – maintenance department reviewed K tag 050 prior to date	02/18/2016

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	transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Report of Monthly Fire Drill" with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 9:32 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 Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		of compliance. Audits – ED/Designee to sign off on all fire drills to ensure documentation of fire monitoring is performed X 6 months. Any negative findings will be reviewed in PI meeting.	
K 0051 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path			

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	of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Activity ' s Storage Room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff only. Findings include: Based on observation with Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:28 p.m., the Activity's Storage Room had smoke detectors located six inches away from an HVAC vents. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)	K 0051	K 051 Immediate – Maintenance department moved the smoke detector away from the vent to standard 36' from air supply on 1.26.16 All others – Audit of all smoke detector was performed by maintenance department prior to date of completion to identify any similar issues. Systemic – maintenance department reviewed K tag 050 prior to date of compliance. Audits – facility will audit smoke detectors monthly X 6 months to ensure proper supervision. Any negative findings will be reviewed in PI meeting.	02/18/2016

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K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of sprinkler system documentation with the Maintenance Supervisor on 01/19/16 at 9:48 a.m., the internal inspection had been performed	K 0062	K 062 Immediate – ED reviewed current quote for flushing system, approx. $72,000.00, and facility verified that it was still valid. All gauges that were out of compliance were changed by a license contractor prior to date of compliance. Internet cables around the sprinkler system were removed by maintenance on 1.22.16. Sprinkler heads that had paint on them were replaced by licensed contractor prior to date of compliance. All others – Audit of sprinkler system was completed by maintenance prior to date of compliance. CER for work to be completed was submitted prior to date of compliance. Safe care can not start the flush until 5.31.16 due to the need for warm weather. Project will take several months ending by 10.31.16. This is due to the fact that they will be taking out sections of pipe to blow them out, but will operate in 4 hour segments to minimize hardship on the facility function. Systemic – Maintenance department reviewed K tag 062 prior to date of compliance. Audits – Sprinkler system will be audited by Maintenance department 1 X per month X 6 months to ensure	10/31/2016

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	by SafeCare on 11/24/14. In the report, SafeCare indicated "performed internal pipe inspection and found all dry sprinkler systems are in need of complete system flush." Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed no flush has been performed. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:10 p.m., the sprinkler pipe located near the Employee Entrance had one gauge installed. The		compliance with K tag 062. Any negative findings will be reviewed in PI meeting.	

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	gauge indicated it was manufactured in 2009. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 11:27 a.m., two ethernet cables were wrapped around the sprinkler pipe in the Main Computer Switch room. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			

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	4. Based on observation and interview, the facility failed to replace 3 of 4 painted sprinkler heads in the Conference Room. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 12:27 p.m., three sprinkler heads were covered in paint in the Conference Room. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0066 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:			

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	(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for residents and 2 of 2 areas where smoking was not permitted was maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff and up to 2 residents. Findings include: Based on observations with the Maintenance Supervisor and Director of Nursing on 01/19/16 between 12:37 p.m. and 1:09 p.m., the following was discovered:	K 0066	K 066 Immediate – Cigarette butts were cleaned up by maintenance prior to date of compliance. All others – a metal container with a self-closing lid was placed in designated smoking areas by maintenance prior to date of compliance. Systemic – Inservice was conducted related to smoking regulations prior to date of compliance. Audits – affected area will be observed by the ED/Designee 1 X per week X 4 weeks, 1 X per month X 3 months and then quarterly until compliance is achieved. Any negative findings will be reviewed in PI meeting.	02/18/2016

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	a) there were at least 30 cigarette butts on the ground in the Employee Parking Lot by the garage. b) there were about 100 cigarette butts in non-covered coffee cans outside the Service Wing entrance. c) there were about 100 cigarette butts on the ground in the Employee Entrance. Based on interview at the time of each observation, the Maintenance Supervisor and Director of Nursing acknowledged each aforementioned condition. 3.1-19(b)			
K 0070 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 policy prohibiting space heaters was maintained. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:17 p.m., a space heater was discovered in the Dietary	K 0070	K 070 Immediate – Space heater was immediately removed. All others – Facility audited for any other space heaters. No findings were noted. Systemic – Dietary manager reviewed K tag 070 Audits – ED/Designee will audit 1 X per month X 6 months if space heaters are in use. Any negative findings will be reviewed in PI meeting.	02/18/2016

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	Manager's office. Based on interview at the time of record review, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition and confirmed the facility has a policy not allowing space heaters at all. 3.1-19(b)			
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 cylinders in Skilled Central Supply of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder	K 0076	K 76 Immediate – Cylinders were properly chained by maintenance on 1.19.16 All others – Oxygen rooms were audited by Maintenance director, prior to date of compliance, to ensure adherence to K tag 076 prior to date of compliance. Systemic – In-service conducted prior to date of compliance related to K tag 076 Audits – ED/Designee to review the oxygen rooms are in	02/18/2016

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	stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:39 p.m., the Skilled Central Supply room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)		compliance with K tag 76 1 X per month X 6 months. Any negative findings will be reviewed in PI meeting	
K 0104 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on record review and interview, the facility failed to ensure 2 of 2 fire/smoke dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least	K 0104	K 104 Immediate – 2567 mentions 6 dampers in my skilled unit and references a conversation with my maintenance director on 10.28.15. Facility only has 2 dampers that are in the core area, and our survey was on 1.19.16. Facility is unsure what surveyor is referencing, but the 2 dampers in Core were inspected by a licensed contractor prior to date of compliance All others – All fire smoke dampers were inspected by a licensed contractor prior to date of	02/18/2016

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	every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Supervisor on 01/19/16 at 10:22 a.m., the last inspection for the six dampers in the facility was 06/22/11. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		compliance. Systemic – Maintenance department reviewed K tag 104 Audits – Maintenance department to audit the need for damper inspection 1 X per month for 6 months. Any negative findings will be reviewed in PI	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 13 of 13 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically	K 0147	K 147 Immediate – All noted surge protectors were immediately removed by maintenance. All others – Facility audit of inappropriate surge protectors was completed by maintenance prior to date of compliance. Systemic – Inservice conducted for staff related to K tag 147 prior	02/18/2016

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	permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with Maintenance Supervisor and Director of Nursing on 01/19/16 between 10:33 a.m. to 1:18 p.m. the following was discovered: a) a surge protector powering another surge protector powering computer components in the Marketing office. Also, a surge protector was powering a microwave. b) a surge protector was powering another surge protector powering computer components in Payroll. c) a surge protector powering another surge protector powering electrical components in the Main Computer Switch Room d) a surge protector was powering two separate vending machines in the Staff Break Room. e) a surge protector was powering another surge protector powering computer components in the Medical Records office. f) a surge protector was powering another surge protector powering computer components in Core's Clean Linen Room. g) an extension cord was powering a		to date of compliance. Audits – Facility to audit the mentioned areas 1 X per month for 6 months. Any negative findings will be reviewed in PI.	

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	sump pump in the Sump Pump Room. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain an electrical outlets in 1 of 1 Riser Room Off the Hallway. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only. Findings include: Based on observations with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 10:44 a.m., there was an outlet cover missing in the Riser Room off the Hallway. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0000				

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Bldg. 02	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: 01/19/16 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Life Safety Code survey, Rensselaer Care Center 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. This facility and it's additions were built prior to March 1, 2003, therefore they were surveyed in accordance with LSC Chapter 19. The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke	K 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly appliedImmediateThis facility respectfully request paper compliance.	

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	detectors. The facility has the capacity for 157 and had a census of 89 at the time of this survey. All areas where residents have customary access were sprinklered. Two detached sheds for general storage were not sprinklered. Quality Review completed on 01/22/16 - DA			
K 0045 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide exterior emergency lighting for 1 of 10 exterior exit discharge paths. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:35 p.m., the exit discharge closest to storage room 20 had a light box. When tested, the exterior	K 0045	K 045 Immediate – All noted areas had illumination corrected by the maintenance department on 2.5.16. All others – All means of egress exit areas were reviewed by maintenance department prior to date of compliance Systemic – Maintenance department reviewed K tag 045 prior to date of compliance. Audits – Mentioned areas will be tested 1 X per week X 4 weeks, 1 X per month X 3 months and then quarterly until 95% compliance is achieved. Any negative findings will be reviewed in PI meeting. Maintenance or designee will complete the audits.	02/18/2016

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	light failed to illuminate. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0046 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview; the facility failed to ensure 14 of 14 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.	K 0046	K 046 Immediate – Maintenance director performed a 30 second test on all battery backup lights and necessary repairs were made prior to date of compliance. All others – 100% audit was conducted of all lights that have a battery back up by maintenance prior to date of compliance. Systemic – maintenance department reviewed K tag 046 prior to date of compliance. Audits – a 30 second test will be performed and documented by the maintenance department 1 X per month X 6 months. Any negative findings will be reviewed in PI meeting and Preventative Maintenance schedule will be followed.	02/18/2016

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	Findings include: Based on record review with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 10:02 a.m., the facility provided the annual test, however, based on interview at the time of record review, the Maintenance Supervisor confirmed that the monthly testing was just "a quick press of the button" and not the required 30 seconds. 3.1-19(b)			
K 0048 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation, and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment	K 0048	K 048 Immediate – Door casings were marked as "smoke barrier door" thus putting our fire exit strategy in compliance. All others – All doors were labeled as either smoke barrier or fire doors prior to date of compliance. Systemic – Maintenance reviewed K tag 048 prior to date of compliance. Audits – Doors will be reviewed monthly to ensure appropriate signage matches our exit strategy X 6 months.	02/18/2016

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	(7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review and observation on 01/19/16 between 10:08 a.m. and 2:32 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a fire barrier. However, there were three sets of doors that were not complete fire barriers, which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0050 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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			

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NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978	

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	only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Report of Monthly Fire Drill" with the Maintenance Supervisor and Director of Nursing on 01/19/16 at 9:32 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 Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0050	K 050 Immediate – Maintenance director reviewed K tag 050 and reported that he does call to verify but failed to document the time and who he spoke with. This will now be documented. All others – Documentation of fire drills will include time of alarm along with who was spoken to at the monitoring company. Systemic – maintenance department reviewed K tag 050 prior to date of compliance. Audits – ED/Designee to sign off on all fire drills to ensure documentation of fire monitoring is performed X 6 months. Any negative findings will be reviewed in PI meeting.	02/18/2016

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	3.1-51(c)			
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include:	K 0062	K 062 Immediate – ED reviewed current quote for flushing system, approx. $72,000.00, and facility verified that it was still valid. All gauges that were out of compliance were changed by a license contractor prior to date of compliance. Internet cables around the sprinkler system were removed by maintenance on 1.22.16. Sprinkler heads that had paint on them were replaced by licensed contractor prior to date of compliance. All others – Audit of sprinkler system was completed by maintenance prior to date of compliance. CER for work to be completed was submitted prior to date of compliance. Safe care can not start the flush until 5.31.16 due to the need for warm weather. Project will take several months ending by 10.31.16. This is due to the fact that they will be taking out sections of pipe to blow them out, but will operate in 4 hour segments to minimize hardship on the facility function. Systemic – Maintenance department	10/31/2016

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	Based on review of sprinkler system documentation with the Maintenance Supervisor on 01/19/16 at 9:48 a.m., the internal inspection had been performed by SafeCare on 11/24/14. In the report, SafeCare indicated "performed internal pipe inspection and found all dry sprinkler systems are in need of complete system flush." Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed no flush has been performed. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the		reviewed K tag 062 prior to date of compliance. Audits – Sprinkler system will be audited by Maintenance department 1 X per month X 6 months to ensure compliance with K tag 062. Any negative findings will be reviewed in PI meeting.	

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	Maintenance Supervisor and Director of Nursing on 01/19/16 at 1:10 p.m., the sprinkler pipe located near the Employee Entrance had one gauge installed. The gauge indicated it was manufactured in 2009. Based on interview at the time of observation, the Maintenance Supervisor and Director of Nursing acknowledged the aforementioned condition. 3.1-19(b)			
K 0104 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on record review and interview, the facility failed to ensure 6 of 6 fire/smoke dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient	K 0104	K 104 Immediate – 2567 mentions 6 dampers in my skilled unit and references a conversation with my maintenance director on 10.28.15. Facility only has 2 dampers that are in the core area, and our survey was on 1.19.16. Facility is unsure what surveyor is referencing, but the 2 dampers in Core were inspected by a licensed contractor prior to date of compliance All others – All fire smoke dampers were inspected by a licensed contractor prior to date of compliance. Systemic – Maintenance department reviewed K tag 104 Audits – Maintenance department to audit the need for damper inspection 1 X per month for 6 months. Any negative findings will be reviewed in PI	02/18/2016

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	practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Supervisor on 10/28/15 at 11:13 a.m., the last inspection for the six dampers in the facility was 11/03/10. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)			