

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155807	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2016
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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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K 0000 Bldg. 01	<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: 08/22/16</p> <p>Facility Number: 000388 Provider Number: 155807 AIM Number: 100454140</p> <p>At this Life Safety Code survey, Rural Health 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.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 50 and had a census of 41 at</p>	K 0000	K00 This plan of correction constitutes written allegation of compliance September 22, 2016. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. This facility respectfully requests desk review to establish compliance effective September 22, 2016.	

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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K 0025 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except one detached wooden shed providing facility storage.</p> <p>Quality Review completed on 08/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Diet</p>	K 0025	<p>K25 WhatCorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The six inch by four-inch square hole in the ceiling of the Ice Pantry was repaired on 9/1/2016. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: This has the potential to affect all residents. No resident was affected. What measures will be put into place or what</p>	09/22/2016			

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K 0046 SS=E Bldg. 01	<p>Kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 11:10 a.m. to 12:00 p.m. on 08/22/16, a six inch by four inch square hole was noted in the ceiling of the Diet Kitchen which was not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier. Based on interview at the time of observation, the Administrator acknowledged the aforementioned opening in the Diet Kitchen ceiling smoke barrier was not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p>		<p>systemic changes will be made to ensure that the deficient practice doesnot recur: Weekly rounding will be conducted by maintenance director/designee to monitor the ceiling for holes that need repairing throughout the facility. How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place: Results will be brought to QA by maintenance director for follow up and review for 6 months, or until 100% compliance is achieved.</p>		

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	<p>Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 16.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 11:10 a.m. to 12:00 p.m. on 08/22/16, the battery operated emergency light attached to the exit sign in the corridor by Room 16 failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Administrator acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed five times.</p> <p>3.1-19(b)</p>	K 0046	<p>K46 WhatCorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The battery was replaced on 9/1/2016 to the EmergencyLight attached to exit sign outside of RM#16. It is currently functioningproperly. How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action(s) will be taken: This has the potential to affect allresidents. No resident was affected. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur: Weekly rounding will be conducted by themaintenance director/designee to ensure that all battery operated EmergencyLights functional and working properly. How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place: Results will be brought to QA bymaintenance director for follow up and review for 6months, or until 100% compliance is achieved.</p>	09/06/2016

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K 0047 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 7 exit signs with battery backup illuminated when the backup battery test button was pushed. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 16.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 11:10 a.m. to 12:00 p.m. on 08/22/16, the exit sign in the corridor by Room 16 failed to illuminate when the backup battery test button for the exit sign was pushed five times. Based on interview at the time of observation, the Administrator acknowledged the exit sign in the corridor by Room 16 failed to illuminate when the backup battery test button was pushed.</p>	K 0047	<p>K47 WhatCorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The battery was replaced on 9/1/2016 to the Exit sign attached to the Emergency Light outside of RM#16. It is currently functioning properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: This has the potential to affect all residents. No resident was affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Weekly rounding will be conducted by the maintenance director and/or designee to monitor that all battery operated Exit signs are functional and working properly. How the corrective action(s) will be monitored to ensure the</p>	09/06/2016	

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K 0050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters and on the third shift for 2 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" documentation with the Administrator during record review from 9:10 a.m. to 11:10 a.m. on 08/22/16, documentation</p>	K 0050	<p>deficient practice will not recur, i.e., what quality assurance program will be put into place: Results will be brought to QA for follow up and review for 6 months, or until 100% compliance is achieved.</p> <p>K50 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Fire drills will be held at unexpected times varying in time and conditions for all 3 shifts. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: This has the potential to affect all residents. No resident was affected. What measures will be put into place or what systemic changes will be made to ensure that the</p>	09/06/2016	

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K 0130 SS=C Bldg. 01	<p>of a fire drill conducted on the second and third shift in the fourth quarter of 2015 was not available for review. In addition, documentation of a fire drill conducted on the third shift in the first quarter of 2016 was also not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of fire drills conducted on the aforementioned shifts and calendar quarters was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 22 of 22 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K 0130	<p>deficient practice does not recur: Monthly fire drills will be held conducted and documented by maintenance director at varying times with at least a 2-hour difference between each fire drill. Quarterly audit sheet will be used to ensure varying times across all shifts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Results will be brought to QA by Maintenance director or designee for follow up and review for 6 months, or until 100% compliance is achieved.</p> <p>K130 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Proper documentation of the Kiddie Model i900 ionization smoke alarm weekly testing and yearly cleaning has been updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: This has the potential to affect all residents. No resident was affected. What measures will be put into place or what</p>	09/06/2016

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	<p>Based on review of "Weekly Smoke Detector Check" documentation with the Administrator during record review from 9:10 a.m. to 11:10 a.m. on 08/22/16, documentation of resident sleeping room battery operated smoke detector cleaning was not available for review for the most recent twelve month period. In addition, documentation of weekly battery operated smoke detector testing for the 23 week period of 08/28/15 through 01/29/16 was not available for review.</p> <p>Based on observations with the Administrator during a tour of the facility from 11:10 a.m. to 12:00 p.m. on 08/22/16, Kidde Model i9010 battery operated smoke detectors were installed in each of 22 resident sleeping rooms in the facility. Review of Kidde Model i9010 ionization smoke alarm information affixed to the back of the battery operated smoke detector in Room 11 stated to "test weekly" and "clean the smoke alarm annually". Based on interview at the time of record review and of the observations, the Administrator acknowledged documentation of resident sleeping room battery operated smoke detector cleaning within the most recent twelve month period and weekly testing for the aforementioned 23 week period was not available for review.</p>		<p>systemic changes will be made to ensure that the deficient practice doesnot recur: Weekly smoke alarm checks will be conductedand properly documented by the maintenance director/designee. Yearly smokealarm cleaning will be conducted and properly documented by the maintenancedirector/designee.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: Results will be brought to QA by maintenancesdirector / designee for follow up and review for 6 months, or until 100%compliance is achieved.</p>	

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K 0144 SS=F Bldg. 01	<p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent</p>	K 0144	<p>K144 WhatCorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: Monthly load tests will be conducted anddocumented with percent of load 9/8/2016. How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action(s) will be taken: This has the potential to affect allresidents. No resident was affected. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur: A 30-minute load test will be conductedmonthly and documented by maintenance/designee. After reach monthly test,results will be audited by administrator to ensure compliance for 3months. How the corrective action(s) will bemonitored to ensure the</p>	09/06/2016			

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	<p>of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly Generator System Service and Testing" documentation for May, June and July 2016 with the Administrator during record review from 9:10 a.m. to 11:10 a.m. on 08/22/16, the generator log form was documented as "Yes" in response to "Load Test" for load testing conducted on 05/25/16, 06/01/16, 06/18/16, 06/22/16, 06/29/16, 07/06/16, 07/20/16 and 07/27/16 but "N/A" in response to "% of Load". Loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer was not available for review for the aforementioned three month period. In addition, documentation of load testing</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Results and schedule will be brought to QA by maintenance director/ designee for follow up and review for 6 months, or until 100% compliance is achieved.</p>	

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	<p>for 07/20/16 and 07/27/16 did not include the generator was run for a minimum of 30 minutes. Based on interview at the time of record review, the Administrator acknowledged documentation of a complete record for monthly load testing for May, June and July 2016 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for 3 of 12 months. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>						

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	<p>Based on review of "Weekly Generator System Service and Testing" documentation for May, June and July 2016 with the Administrator during record review from 9:10 a.m. to 11:10 a.m. on 08/22/16, the generator log form was documented as "2 sec" in response to "Cool Down" for load testing conducted on 05/25/16, 06/01/16, 06/18/16, 06/22/16, 06/29/16, 07/06/16, 07/20/16 and 07/27/16. Based on interview at the time of record review, the Administrator acknowledged emergency generator load testing documentation for the three month period of May through July 2016 did not state a minimum time delay of 5 minutes was provided for unloaded running of the emergency generator prior to shutdown. Based on observation with the Administrator during a tour of the facility from 11:10 a.m. to 12:00 p.m. on 08/22/16, the manufacturer's nameplate affixed to the emergency generator stated the unit was rated at 30 kW.</p> <p>3.1-19(b)</p>			