

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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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: 02/23/16</p> <p>Facility Number: 012966 Provider Number: 155803 AIM Number: 201110390</p> <p>At this Life Safety Code survey, Hamilton Pointe Health and Rehab 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered, except the sprinkler riser room. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 115</p>	K 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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K 0042 SS=E Bldg. 01	<p>and had a census of 99 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review complete on 02/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 rooms of more than 2500 square feet had at least two exit access doors remote from each other. LSC 18.2.5.3 states any room other a patient sleeping room, of more than 2500 square feet shall have not less than two exit access doors remotely located from each other. This deficient practice could affect more than 10 residents, as well as staff and visitors while in the Physical Therapy Room.</p> <p>Findings include:</p> <p>Based on observation on 02/23/16 at 12:10 p.m. during a tour of the facility with the Maintenance Supervisor, the Physical Therapy Room was 63 foot by</p>	K 0042	<p>1) Immediate actions taken for those residents identified:</p> <p>No residents have had any adverse effects related to the deficiency.</p> <p>2) How the facility identified other residents:</p> <p>All residents that receive therapy services in the therapy gym have the potential to be affected by this alleged deficient practice.</p> <p>3) Measures put into place/ System changes:</p> <p>Contractor scheduled to install additional door to therapy gym. Maintenance/designee shall ensure safety during weekly environmental</p>	03/24/2016

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K 0056 SS=E Bldg. 01	<p>42 foot (2,646 square feet) in size. There was only one exit from this room which was into the corridor where the 500, 600, and 700 units meet. 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 There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 11 smoke compartments. This deficient practice could affect over 50 residents, as well as staff and visitors while in the north dining room.</p> <p>Findings include:</p>			K 0056	<p>rounds according to facility protocol.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p> <p>1) Immediate actions taken for those residents identified:</p> <p>No residents have had any adverse effects related to the deficiency.</p> <p>2) How the facility identified other residents:</p> <p>All residents present in north dining room have the potential to be</p>		03/24/2016

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K 0144 SS=C Bldg. 01	<p>Based on observation on 02/23/16 at 11:30 a.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler riser room within the north dining room was not provided with sprinkler coverage. There were no sprinkler head in this room. 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 ensure 1 of 1 emergency generators was documented to have a minimum 5 minute cool down period after a load test. 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</p>	K 0144	<p>affected by this alleged deficient practice.</p> <p>3) Measures put into place/ System changes:</p> <p>Sprinkler head was installed February 4, 2016 in sprinkler riser room. Maintenance/Designee shall complete weekly TELS checks specific to sprinkler safety according to facility policy.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p> <p>1) Immediate actions taken for those residents identified: No residents have had any adverse effects related to the deficiency. 2) How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3) Measures put into place/ System changes: Monthly generator log was amended to include an area to document 'Run</p>	03/24/2016	

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	<p>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, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly load test on 02/23/16 at 10:45 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. During an interview at the time of record review, the Maintenance Supervisor said the generator does have a cool down time of 10 minutes, but confirmed the monthly generator log did not include documentation of a cool down time being recorded.</p> <p>3.1-19(b)</p>		<p>Time' and 'Cool down Time.' Immediate re-education provided to the maintenance department related to all areas required to document during generator testing. Maintenance/designee shall audit generator log monthly for completion and accuracy monthly. 4) How the corrective actions will be monitored: The results of these audits will be reviewed monthly x 3 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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