

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2012
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NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/30/12</p> <p>Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Fairmont Rehabilitation Center, LLC 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 105 and had</p>	K0000		

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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	<p>a census of 59 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage, however, the facility was not in compliance with smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the one detached garage and one detached rental pod which provided facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0143 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 1 of 1 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire barrier enclosure. This deficient practice could affect 15 residents on 100 hall as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 10/30/12 at 2:22 p.m. with the Maintenance Supervisor, the door to the Oxygen transfer room on 100 hall had a manufacturer's tag which verified it to be a twenty minute fire rated door. Based on interview on 10/30/12 at 2:23 p.m., it was acknowledged by the Maintenance Supervisor oxygen transfer</p>	K0143	<p><b><u>Corrective Action:</u></b> The oxygen room door was inspected and found not to be a one hour fire barrier door.</p> <p><b><u>Identification:</u></b> Residents have the potential to be affected by this alleged deficient practice of not having the one hour fire barrier door.</p> <p><b><u>System Change:</u></b> A new door with one hour fire rating has been order on 11/19/12 and will be delivered and installed by 12/21/12</p> <p><b><u>Monitoring:</u></b> The door will be inspected on a monthly base during the preventive maintenance audit.</p>	12/21/2012	

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	occurs in the Oxygen transfer room and the fire rating of the corridor door to the oxygen transfer room was a twenty minute door.  3.1-19(b)			

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K9999	<p>State Findings:</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice could affect at least 59 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K9999	<p><b><u>Corrective Action:</u></b></p> <p>The resident rooms have been identified as not having a battery operated or hard wired smoke detectors.</p> <p><b><u>Identification:</u></b></p> <p>Residents have the potential to be affected by this alleged deficient practice due to no smoke detectors in the rooms.</p> <p><b><u>System Change:</u></b></p> <p>50 smoke detectors were purchased on 11/9/12 and installed in resident rooms on 11/13/12. Every month the Smoke Detective batteries will be check and replaced if needed and documented on the Preventive Maintenance Resident room check sheet.</p> <p><b><u>Monitoring:</u></b></p> <p>The Environmental Director will review with the Administrator the documented inspections of the resident rooms on weekly bases for 1 month, then monthly there after. The Administrator and/or designee will complete an inspection of 9 rooms completed on a weekly bases for 1 month and then random inspections monthly there after. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and</p>	11/13/2012			

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	<p>Maintenance Supervisor on 10/30/12 from 12:30 p.m. to 1:45 p.m., the following resident rooms were not provided with smoke detectors: rooms 100 to 321 a total of fifty resident rooms. Based on interview during the time of observations, the Maintenance Supervisor acknowledged none of the resident rooms were provided with smoke detectors.</p> <p>3.1-19(ff)</p>		recommendations.	