

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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K020000	<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: 05/15/14</p> <p>Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bridgewater 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, in areas open to the corridors and hard wired smoke detectors in 15</p>	K020000	<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>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</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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K020130 SS=E	<p>resident rooms. Battery operated smoke detectors are installed in the remaining 25 resident rooms. The facility has a capacity of 78 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 4 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and</p>	K020130	<p>1.No residents were affected by this alleged deficient practice. The insulation in the gap of the fire barrier wall by room 102 has been removed and gap has been sealed with fire resistant caulk.</p> <p>2.All residents on the 100 hall had the potential to be affected. No residents were affected by this alleged deficient practice. The insulation in the gap of the fire barrier wall by room 102 has been removed and gap has been sealed</p>	05/21/2014

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	<p>similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 05/15/14 at 2:45 p.m., at the fire barrier wall near resident room 102 above the lay in ceiling there was fiberglass insulation</p>		<p>with fire resistant caulk.</p> <p>3.Other fire barrier walls were inspected with no deficient practice noted. Maintenance Supervisor has been re-educated in regards to fire barrier walls. The Maintenance Supervisor has added inspecting fire barrier walls to the preventative maintenance schedule.</p> <p>4.Maintenance Supervisor will complete inspection of fire barrier walls monthly times 3 months then quarterly thereafter. Any negative findings will be reported to the administrator immediately. Results of these reviews will be forwarded to the QA committee monthly times 3 months then quarterly thereafter and the plan adjusted if indicated.</p>				

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K020144 SS=C	<p>stuffed in the gap between the drywall ceiling and the fire barrier wall. This was acknowledged by the Director of Maintenance 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 provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupant.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Emergency Generator Weekly Inspection Checklist" with the Director of</p>	K020144	<p>1.No residents were affected by this alleged deficient practice. A column for transfer time has been added to the monthly generator inspection form.</p> <p>2.All residents had the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. A column for transfer time has been added to the monthly generator inspection form.</p> <p>3.Maintenance Supervisor re-educated on proper form for generator inspection. Administrator to review generator log monthly times 3 months then quarterly thereafter to ensure form contains proper information.</p> <p>4.Administrator to review generator log monthly times 3 months then quarterly thereafter to ensure form contains proper</p>	05/21/2014

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	Maintenance on 05/15/14 at 12:50 p.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator for the months of February through May 2014. This was acknowledged by the Director of Maintenance. 3.1-19(b)		information. Results of these reviews will be forwarded to the QA committee monthly times 3 months then quarterly thereafter and the plan adjusted if indicated.		