

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------|--|---------|--|--|
| K010000 | <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/30/13</p> <p>Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Milner Community Health 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a two hour separation from an assisted living occupancy located on the west side of the building. The west emergency exit from</p> | K010000 | <p>Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc. that the allegations contained in this survey report are a true and accurate portrayal of the provisions of nursing care and services at this health care facility. Milner Community Health Care, Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. We respectfully request that a desk review be completed, all plan of corrections have been completed as stated. Please accept this Plan of Correction as the 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | |
| (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 | |
| | <p>the A Hall requires passing through one smoke compartment of the assisted living unit. 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 detectors. The facility has the capacity for 80 and had a census of 61 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 with the exception of one detached storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 | |
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | | |
| (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 | | | |
| K010062 SS=E | <p>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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 84 resident room sprinkler heads were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 4 or more residents on the east wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/30/13 between 1:50 p.m. and 2:05 p.m., ceiling mounted brackets in resident rooms E-2 and E-4 were located such that the televisions could obstruct sprinkler protection located nearest a storage alcove between wardrobes in the resident rooms. The maintenance director acknowledged at the time of observation, the televisions appeared to be mounted directly in front of the sprinklers and could obstruct the</p> | K010062 | <p>It is the policy of this facility to continuously maintain the automatic sprinkler system in a reliable operating condition and to have it inspected and tested periodically.1. The television brackets in E-2 and E-4 have been removed from the ceiling so as not to obstruct the sprinkler protection located near the storage alcove between wardrobes in the residents rooms.2. All television brackets in the residents rooms will be removed from the ceiling by June 28, 2013.3. Maintenance staff were re-education on June 13, 2013 regarding the appropriateness of placing equipment so as not to impede sprinkler spray pattern.4. Director of Environmental Services will monitor all new television brackets added to residents rooms for proper placement. Director of Environmental Services to check monthly via monthly preventative maintenance checklist.Completion Date 6-28-13 and ongoing</p> | 06/28/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | spray pattern protecting the alcove. 3.1-19(b) | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| K010064 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect visitors, staff and 20 or more residents residents using the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> | K010064 | <p>It is the policy of this facility to provide appropriate portable fire extinguishers in accordance with regulations.1. Director of Environmental Services immediately contacted Ace Fire Protection, our contracted services, to have a placard placed on fire extinguisher.2. All other extinguishers were checked to ensure proper placard was attached to the fire extinguishers, where appropriate.3. Maintenance staff and Dietary supervisor were re-educated on June 13, 2013 regarding proper placards being attached to fire extinguishers.4. Director of Environmental Services will add to monthly preventative maintenance checklist to ensure placards are in place.Completion date 6-28-13 and ongoing</p> | 06/28/2013 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>Based on observation with the maintenance director on 05/30/13 at 2:30 p.m., an instruction placard had not been placed in the kitchen for the K-class fire extinguisher in the kitchen. The maintenance director said at the time of observation, he was unaware of the requirement.</p> <p>3.1-19(b)</p> | | | |

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 | |
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | | |
| (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 | | | |
| K010130 SS=C | <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure certificates of inspection for 2 of 3 boilers/service water heaters were not expired. LSC 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 05/30/13 between 12:25 p.m. and 3:00 p.m. with the maintenance director, boiler # 314344 in the boiler room and laundry room service water heater # 261856 each had certificates of inspection which expired on 03/16/13. The maintenance director said at the time of observation, the inspections had been recently done but there was no documentation to support the visit or information provided as to the results of the inspection.</p> <p>3.1-19(b)</p> | K010130 | <p>It is the policy of this facility to ensure boiler inspections are done timely and certificates of inspection are available.1. Fire Marshall's office was here on May 22, 2013 for the annual boiler inspection. Report of Inspections were received by this facility on June 4, 2013.2. Facility ensured that Report of Inspection was recieved for all boilers inspected on the above date.3. Upon future inspections, Director of Environmental Services will obtain written documentation prior to the inspector leaving the building.4. Director of Environmental Services will add to annual preventative maintenance form and will call the Fire Marshall's office one month prior to expiration date to ensure timely inspection.Date of Completion 6-28-13 and on going</p> | 06/28/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 | |
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | | |
| (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 | | | |
| K020000 | <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/30/13</p> <p>Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Milner Community Health Center was found not in compliance 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), and 410 IAC 16.2. The 2010 sunroom addition to the main dining room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a two hour separation from an assisted living occupancy located on the west side of the building. The west emergency exit from</p> | K020000 | <p>Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc. that the allegations contained in this survey report are a true and accurate portrayal of the provions of nursing care and services at this health care facility. Milner Community Health Care, Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion.We respectfully request that a desk review be completed, all plan of corrections have been completed as stated.Please accept this Plan of Correction as the Credible Allegation of Compliance.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>the A Hall requires passing through one smoke compartment of the assisted living unit. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 80 and had a census of 61 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 with the exception of one detached storage shed.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 | |
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | | |
| (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 | | | |
| K020064 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect visitors, staff and 20 or more residents residents using the main dining room which is open to the sunroom and located adjacent to the kitchen.</p> <p>Findings include:</p> | K020064 | <p>It is the policy of this facility to provide appropriate portable fire extinguishers in accordance with regulations.1. Director of Environmental Services immediately contacted Ace Fire Protection, our contracted services, to have a placard placed on fire extinguisher.2. All other extinguishers were checked to ensure proper placard was attached to the fire extinguishers, where appropriate.3. Maintenance staff and Dietary supervisor were re-educated on June 13, 2013 regarding proper placards being attached to fire extinguishers.4. Director of Environmental Services will add to monthly preventative maintenance checklist to ensure placards are in place.Completion date 6-28-13 and ongoing</p> | 06/28/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>Based on observation with the maintenance director on 05/30/13 at 2:30 p.m., an instruction placard had not been placed in the kitchen for the K-class fire extinguisher in the kitchen. The maintenance director said at the time of observation, he was unaware of the requirement.</p> <p>3.1-19(b)</p> | | | |

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155676 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/30/2013 | |
| NAME OF PROVIDER OR SUPPLIER MILNER COMMUNITY HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065 | | | |
| (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 | | | |
| K020130 SS=C | <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure certificates of inspection for 2 of 3 boilers/service water heaters were not expired. LSC 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 05/30/13 between 12:25 p.m. and 3:00 p.m. with the maintenance director, boiler # 314344 in the boiler room and laundry room service water heater # 261856 each had certificates of inspection which expired on 03/16/13. The maintenance director said at the time of observation, the inspections had been recently done but there was no documentation to support the visit or information provided as to the results of the inspection.</p> <p>3.1-19(b)</p> | K020130 | <p>It is the policy of this facility to ensure boiler inspections are done timely and certificates of inspection are available.1. Fire Marshall's office was here on May 22, 2013 for the annual boiler inspection. Report of Inspections were received by this facility on June 4, 2013.2. Facility ensured that Report of Inspection was recieved for all boilers inspected on the above date.3. Upon future inspections, Director of Environmental Services will obtain written documentation prior to the inspector leaving the building.4. Director of Environmental Services will add to annual preventative maintenance form and will call the Fire Marshall's office one month prior to expiration date to ensure timely inspection.Date of Completion 6-28-13 and on going</p> | 06/28/2013 | | | |