

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2013
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NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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K010000	<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: 03/18/13</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rockville Nursing and Rehabilitation 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, fully sprinklered facility was determined to be of Type II (111) construction with an attached covered front entry porch of Type V (000) construction which was fully sprinklered. The facility was considered Type V (000)</p>	K010000		
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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>construction for the purpose of this survey. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in all resident rooms. The facility has the capacity for 38 and had a census of 32 at the time of this survey.</p> <p>All areas accessible to residents were sprinklered. All areas providing facility services were sprinklered except three detached structures housing storage and a maintenance area.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/20/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 2 smoke compartments would latch automatically into the door frame. This deficient practice affects staff, visitors and 10 or more residents the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/13 at 11:30 a.m., the corridor door to the south janitor's closet was equipped with a deadbolt lock which was the only means to secure the door in the door frame. If the lock was not engaged the door could not be held tightly in the door frame</p>	K010018	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 018 Latching Devices</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>The existing deadbolt lock was removed and replace with a</p>	03/30/2013			

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	without the use of a key. 3.1-19(b)		<p>one way locking-latching doorknob.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, vender, employee or visitor has the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The Maintenance Director was re-educated on the importance of having the appropriate door locks on all doors at all times. A facility wide audit was completed to identify any other areas. None were found.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e.</p>	

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			<p>what quality assurance program will be put into place:</p> <p>The monitoring will be completed by the NHA/Designee during daily rounds. A quarterly monitoring by the Director of plant ops/Designee will be conducted. A report of their findings will be reviewed at the monthly risk management/QA meeting.</p> <p>(e) Date of compliance: 3/30/13</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 2 of 2 service water heaters had unexpired certificates of inspection. 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 affects visitors, staff and 20 or more residents in the north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 03/18/13 at 10:15 a.m. with the maintenance director, two service water heaters in the boiler room had certificates of inspection which expired on 01/18/13. The maintenance director said at the time of observation, inspectors were last notified 01/18/13 the inspections were due. He said there was no inspection done and no date had been set for the inspection.</p> <p>3.1-19(b)</p>	K010130	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 130 Inspection of Water Heaters</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>An inspection was completed by Steven Polley, Field Inspector of the Boiler Division, on the two service water heaters on March 28, 2013, and both passed the inspection.</p> <p>(b) How you will identify other residents having potential to be affected by the same</p>	03/30/2013	

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			<p>practice and what corrective action will be taken:</p> <p>Any resident, vender, employee or visitor has the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The Maintenance Director was re-educated on the importance of timely inspections of the service water heaters prior to the expiration date.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>The monitoring will be completed by the NHA/Designee during monthly maintenance rounds. A quarterly monitoring by the Director of Plant Ops/Designee will be conducted. A report of their findings will be reviewed at the monthly risk</p>		

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			management/QA meeting. (e) Date of compliance: 3/30/13		