STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	614 WEST 14TH STREET MARION, IN 46953

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K010000	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). Survey Date: 2/09/15 Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580 Surveyor: Thomas Forbes, Life Safety Code Specialist At this Life Safety Code survey, Marion Rehabilitation and Assisted Living Center was found not in compliance with 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. This one story facility with a partial basement 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, areas open to the corridors and resident	K010000	This plan of correction is prepared and executed because the provision of State and Federal Law require it and not because Marion Rehabilitation & Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains the alleged deficiencies do not jeopardize the health and safety of our guests, nor are they of such character so as to limit our capability to render adequate care. This facility respectfully request a desk review/paper compliance of the allegations addressed in this POC.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	rooms. The facility has a capacity of 70 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/11/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure 2 of 2 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC	K010025	No residents were found to be affected by this deficient practice. This deficient practice could affect 1 of 2 basement smoke compartments and 1 of 3 resident	03/06/2015

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	8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 1 of 2 basement smoke compartments and 1 of 3 resident care area smoke compartments. Findings include: Based on observations with the Director of Environmental Services on 02/09/15 during a tour of the facility from 10:30 a.m. to 2:00 p.m., the following areas had unsealed ceiling penetrations: a) in the house keeping closet located in the basement measuring one fourth of an inch in size around a drain pipe, and one eighth of an inch in size around a sprinkler head. b) in the laundry room located in the basement measuring one eighth of an inch in size around a sprinkler head. c) in the house keeping closet located by room C103 there where three cracks in the fire caulk measuring one eighth of an inch in size and one inch long. Base on interview during the tour, this was acknowledged by the Director of Environmental Services at the time of observations. 3.1-19(b)		care area smoke compartments. The Environmental Service Director has purchase a fire resistant rated caulking (minimum one-hour) Grabbergard GGIFC10 Intumescent fire caulk. The Environmental Service Director will inspect the entire facility and where any penetrations are found defective or absent of caulking the repair or absent area will be applied with the fire resistant caulking. The Environment Service Director will visually inspect all penetrations as an ongoing rounds added to the TELS preventive maintenance tracking system and services will be performed when in the facility. Any deficient area will be repaired and or applied and will inform the committee during the monthly QA meeting.	

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K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer locations greater than 3,000 cubic feet are vented to the outside by a continuous mechanical ventilation system. This deficient practice could affect 34 residents in D wing. Findings include: Based on observations with the Director of Environmental Services on 02/09/14 at 12:12 p.m., the oxygen storage room in D wing did not have a working mechanical ventilation system. Based on interview at the time of the observations, the Director of Environmental Services acknowledged the mechanical ventilation system in the oxygen storage room was not working preventing continuous mechanical ventilation.	K010076	No residents were found to be affected by this deficient practice. This deficient practice had the potential to affect 34 residents in D wing of the facility. The exhaust fan was purchased on 2/11/2015 and delivered on 2/13/2015 and installed on 2/13 /2015 by the Environmental Services Director. The Environmental Services Director will audit the proper working condition of the exhaust fan in the oxygen storage room and put on the TELS weekly preventive maintenance tracking system. Any issues will be corrected and discussed in the monthly QA meeting.	02/13/2015

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	3.1-19(b)			
K010130 SS=B	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 2 of 2 boilers had a current inspection certificate to ensure the boilers were in safe operating condition. NFPA 101, in 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 residents. This deficient practice was not in a resident care area but could affect any number of staff in the basement. Findings include: Based on observation and record review with the Director of Environmental Services on 02/09/15 between 10:30 a.m. and 12:44 p.m., two boilers located in the basement lacked a Certificate of Inspection. Based on an interview with the Director of Environmental Services; the Boilers were inspected by Duncan Services Co. on 10-30-14, but no state Certificate of Inspection was sent to the facility. 3.1-19(b)	K010130	No residents were found to be affected by this deficient practice.This deficient practice was not in a resident care area but could potentially affect any number of staff in the basement.The Duncan Service Company inspected the boilers on 10/30/2014 but did not send inspection to the state for issuance of certification. The Duncan Service Company was contacted and have sent the inspection to the State department to issue the 2 boilers certificates to be posted with each boiler.The Environment Service Director will add the certification inspection to the preventive maintenance yearly rounds. Any discrepancy will be corrected and brought to the monthly QA meeting.	03/18/2015

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