

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2012
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NAME OF PROVIDER OR SUPPLIER DECATUR TOWNSHIP CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4851 TINCHER RD INDIANAPOLIS, IN 46221
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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: 08/13/12</p> <p>Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Decatur Township Care 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 facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p>	K0000	<p>1. K0000 The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Decatur Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</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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	<p>corridor. The facility has battery operated smoke detection in all resident sleeping rooms. The facility has a capacity of 88 and had a census of 78 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services which includes a smoking shed and a storage building which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 openings through the ceiling into the attic above the Boiler room was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any staff or visitor in the vicinity of the Boiler room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 08/13/12, a one foot diameter hole in the ceiling in the Boiler room was not firestopped. In addition, the annular space surrounding a one inch in diameter gas line which penetrates the ceiling of the Boiler room was also not firestopped. Based on interview at the time of the observations, the Maintenance</p>	K0025	<p>2. K0025 a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director repaired the openings immediately and ensured its safety. d. The Maintenance Director/Designee will monitor facility for other openings for compliance weekly X2 for one week, then monthly X3 or until 100% of accuracy is obtained.</p>	08/30/2012			

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	Supervisor acknowledged the aforementioned locations in the Boiler room were not firestopped. 3.1-19(b)			

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered emergency lights for 12 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff or visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the "TELS: Logbook" with the Maintenance Supervisor at 1:30 p.m. on 08/13/12, documentation of annual ninety minute testing for each of two battery powered emergency lights was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged</p>	K0046	<p>3. K0046 a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. On 08/13/12, the battery operated emergency lighting was tested by Maintenance Director. Maintenance Director has added inspection of battery powered emergency lighting, at minimum annually, to monitoring system. d. The Maintenance Director/Designee will monitor testing system compliance weekly X1 for two weeks, then monthly thereafter and annually as required.</p>	08/30/2012			

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	<p>documentation of annual ninety minute testing of the two facility's battery powered emergency lights was not available for review. Based on observations with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 08/13/12, a functioning battery powered emergency light was located at the emergency generator outside the building and at the transfer switch inside the building.</p> <p>3.1-19(b)</p>			

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K0048 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Preparedness Policy & Procedure Manual: Fire Evacuation and Disaster Plan" with the Maintenance Supervisor from 10:30 a.m. to 12:15 p.m. on 08/13/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire</p>	K0048	<p>4. K0048 a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. On 8/13/12, Decatur Township Care and Rehabilitation Center implemented a plan of protection of residents, staff, and visitors for use of ABC type fire extinguishers and the K-class fire extinguisher(s) and the extinguishment of fire to Emergency Preparedness Plan. Maintenance Director immediately posted K-class fire extinguisher sign next to the fire extinguisher. Dietary staff to be in-serviced by 8/30/12. d. The Maintenance Director/Designee will adjust the policy and procedure and will be placed in appropriate manuals and reviewed at the next monthly QA meeting.</p>	08/30/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>			

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K0052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K0052	<p>5. K0052 a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director/Designee will be in-serviced by 8/30/12 on the proper labeling necessary for connections dedicated to branch circuits and labeled correctly. Proper labeling was corrected on 8/13/12. d. The Maintenance Director/Designee will monitor labeling compliance monthly for one quarter to assure labeling is complete.</p>	08/30/2012			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 08/13/12, the fire alarm system breaker could not be located or identified. Based on interview at the time of observation, the Maintenance Supervisor stated he did not know the location of the fire alarm system breaker in the facility and acknowledged the fire alarm system breaker could not be located or identified.</p> <p>3.1-19(b)</p>			

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K0062 SS=C	<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 record review, observation and interview; the facility failed to ensure 3 of 3 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 10:30 a.m. to 12:15 p.m. on 08/13/12, documentation of annual fire hydrant testing within the last twelve months was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated fire hydrant inspection documentation was not available for review and acknowledged it has been</p>	K0062	<p>6. K0062</p> <p>a. No residents, staff, or visitors were adversely affected by this deficient practice.</p> <p>b. Residents, staff, and visitors had the potential to be affected by this deficient practice.</p> <p>c. The Maintenance Director/Designee will inspect/test all deficient fire hydrants by 8/30/12.</p> <p>d. The Maintenance Director/Designee will continue to monitor annually and/or after each use.</p>	08/30/2012

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	<p>more than twelve months since the last annual inspection of the facility's fire hydrants. Based on observations with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 08/13/12, the facility has one fire hydrant in the parking lot and two fire hydrants along the access road to the facility. Based on interview at the time of the observations, the Maintenance Supervisor stated the three fire hydrants were owned by the facility.</p> <p>3.1-19(b)</p>			

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K0069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any staff or visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 10:30 a.m. to 12:15 p.m. on 08/13/12, documentation of semiannual kitchen range hood cleaning was not available for review.</p>	K0069	<p>7. K0069 a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. Due to the passage of time, Maintenance Director/Designee cannot inspect kitchen exhaust for proper cleaning. Maintenance Director has added kitchen hood inspection, at minimum semiannually, to monitoring system. Kitchen hood was cleaned by vendor on 8/15/12. d. The Maintenance Director will monitor the inspection of the facility's hood inspection cleaning system ongoing semiannually, or as needed, per regulation.</p>	08/30/2012			

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	<p>Based on observation with the Maintenance Supervisor, Housekeeping Manager and Administrator during a tour of the facility from 12:15 p.m. to 2:50 p.m. on 08/13/12, Indy Exhaust had affixed one sticker to the kitchen range hood stating "Date Cleaned" as "09/12/11" and "Date Due" for the next cleaning as "March 2012". Based on interview at the time of observation, the Maintenance Supervisor stated the facility did not perform semiannual kitchen range hood cleaning on or after March 2012 and acknowledged documentation of semiannual kitchen exhaust system cleaning was not available for review.</p> <p>3.1-19(b)</p>			

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K0076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect two residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:50 p.m. on 08/13/12, the oxygen storage and transfilling room ceiling consisted of one layer of five eighths inch thick drywall. Four liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged</p>	K0076	<p>8. K0076</p> <p>a. No residents, staff, or visitors were adversely affected by this deficient practice.</p> <p>b. Residents, staff, and visitors had the potential to be affected by this deficient practice.</p> <p>c. The Maintenance Director/Designee repaired deficient ceiling barrier on 8/17/12.</p> <p>d. The Maintenance Director/Designee will monitor compliance monthly for one month to assure new construction is sufficient.</p>	08/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2012
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NAME OF PROVIDER OR SUPPLIER DECATUR TOWNSHIP CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4851 TINCHER RD INDIANAPOLIS, IN 46221
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	<p>the oxygen storage and transfilling room ceiling did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>			

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K0143 SS=D	<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 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any two residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, Housekeeping Manager and the Administrator during a tour of the facility from 12:15 p.m. to 1:50 p.m. on 08/13/12, the oxygen storage</p>	K0143	<p>9. K0143</p> <p>a. No residents, staff, or visitors were adversely affected by this deficient practice.</p> <p>b. Residents, staff, and visitors had the potential to be affected by this deficient practice.</p> <p>c. The Maintenance Director/Designee repaired deficient ceiling barrier on 8/17/12.</p> <p>d. The Maintenance Director/Designee will monitor compliance monthly for one quarter to assure new construction is sufficient.</p>	08/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2012
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	<p>and transfilling room ceiling consisted of one layer of five eighths inch thick drywall. Four liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Administrator stated oxygen transfilling does occur in the room and the Maintenance Supervisor acknowledged the oxygen storage and transfilling room ceiling did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>			