| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 06/19/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRECKENRIDGE HEALTH & REHABILITATION | 325 W NORTHWOOD DR<br>SULLIVAN, IN 47882 |

| (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 | 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).<br><br>Survey Date: 06/19/14<br><br>Facility Number: 000525<br>Provider Number: 155468<br>AIM Number: 100267010<br><br>Surveyor: Bridget Brown, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Breckenridge Health & Rehabilitation 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.<br><br>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 system wide hardwired smoke detection in corridors and in spaces open to the corridors. | K010000 | Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155468 | | 06/19/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRECKENRIDGE HEALTH & REHABILITATION | 325 W NORTHWOOD DR<br>SULLIVAN, IN 47882 |

| (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 |
|---|---|---|---|---|
| | Hardwired smoke detectors with local alarms were provided in 300 hall resident rooms and battery powered smoke detectors in resident sleeping rooms on the 100 and 200 halls. The facility has a capacity of 57 and had a census of 37 at the time of this survey.<br><br>All areas where residents had customary access and providing facility services were sprinklered.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/30/14.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |
| K010021<br>SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:<br><br>a) the required manual fire alarm system;<br><br>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 06/19/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 W NORTHWOOD DR SULLIVAN, IN 47882 | |

| (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 |
|---|---|---|---|---|
| | c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2<br>Based on observation and interview, the facility failed to ensure access doors to 2 of 5 hazardous areas such as a kitchen and laundry were held open only with devices which allowed the door to close automatically or upon activation of the fire alarm. This deficient practice could affect visitors, staff and 10 or more residents.<br><br>Findings include:<br><br>a. Based on observation with the maintenance director on 06/19/14 at 12:10 p.m., the self closing door between the laundry and service corridor was prevented from closing by a hall tree placed in front of the open door.<br>b. Based on observation with the maintenance director on 06/19/14 at 12:35 p.m., the self closing door between the kitchen and dining room was prevented from closing by a wooden wedge.<br>The maintenance director agreed at the time of the observations, the doors should not have been prevented from closing.<br><br>3.1-19(b) | K010021 | K 021 Requires that any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosureis held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:a) The required manual fire alarm systemsb) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system, andc) The automatic sprinkler system, if installed. The facility will ensure this requirement is met through the following corrective measures. 1) Doors in hazardous areas such kitchen and laundry will be shut at all times. These doors will not be propped at any time to prevent them from closing. 2) All residents have the potential to be affected. No residents were affected. 3) All staff Inserviced on Life Safety Code K021 and the importance of having doors shut and not propping them open. Dietary staff and Laundry staff instructed to keep doors closed at all times. Dietary will serve meal trays by manually opening door each time tray served. Laundry will under no circumstances prop door open from laundry room to corridor. 4) The Administrator will conduct rounds to ensure that | 07/18/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155468 | | 06/19/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRECKENRIDGE HEALTH & REHABILITATION | 325 W NORTHWOOD DR<br>SULLIVAN, IN 47882 |

| (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 |
|---|---|---|---|---|
| | | | door in laundry room and kitchen are not propped open at any time. These rounds will be conducted by Administrator or Designee daily on normal scheduled work days x 4 weeks, one time weekly x4 weeks, every 2 weeks x2 months and quarterly thereafter. | |
| K010062<br>SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br>1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the medicine room was free of foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the center smoke compartment.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 06/19/14 at 11:35 a.m., two sprinkler heads protecting the area behind the gas dryers in the laundry were coated with a fuzzy gray grime. The maintenance director acknowledged at the time of observation, the sprinkler heads should have been free | K010062 | K062 Requires automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested. The facility will ensure this requirement is met through the following corrective measures. 1) Sprinkler head in med room will be cleaned and free of grime per Maintenance. Two sprinkler heads protecting the area behind the gas dryers in the laundry will be cleaned and free of fuzzy gray grime. This will also be done per Maintenance. The Sprinkler head in the soiled utility room will have a sprinkler head escutcheon placed per Safecare. This will make the sprinkler head complete. 2) All residents have the potential to be affected. No residents were affected. 3) Maintenance Director will be inserviced on the importance of | 07/18/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | X3) DATE SURVEY COMPLETED 06/19/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 W NORTHWOOD DR SULLIVAN, IN 47882 | |

| (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 |
|---|---|---|---|---|
| | of the grime.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 5 hazardous areas such as a room used for the collection of soiled linen and trash receptacles was maintained. This deficient practice could affect staff, visitors and 10 or more residents in the center smoke compartment.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 06/19/14 at 11:50 a.m., the sprinkler head escutcheon was missing for the sprinkler head protecting the soiled utility room. The maintenance director acknowledged, the sprinkler assembly was incomplete without the escutcheon.<br><br>3.1-19(b) | | sprinkler heads being clean, in good repair and complete. 4) Monitoring will be done per Maintenance Director. This will be done one time weekly x4 weeks, then every 2 weeks for x2 months, then quarterly thereafter. | |