

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441
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K 0000 Bldg. 01	<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: 07/21/16</p> <p>Facility Number: 000333 Provider Number: 155414 AIM Number: 100288370</p> <p>At this Life Safety Code survey, Linton 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 facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000	K000 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 as a requirement of compliance.	
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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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K 0050 SS=F Bldg. 01	<p>and had a census of 26 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached wood sheds used for facility storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 07/21/16 at 9:15 a.m. with the Maintenance Director present, the facility</p>	K 0050	<p>K050 It is the intent of this facility to comply with all LifeSafety Code Regulations. All residents,visitors and staff have the potential to be affected by a deficiency in thispractice. The corrective action and measure(s) put into place to ensure thatthis deficient practice does not recur are that the maintenance director will holdfire drills as required on varying shifts and at varying times. Record of each drill will include the time ofthe drill,</p>	07/29/2016			

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	<p>lacked fire drill documentation for the first shift (day) of the fourth quarter (October, November, and December) of 2015. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 2 of 11 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 07/21/16 at 9:15 a.m. with the Maintenance Director present, fire drills performed during the third shift of the third quarter (July, August and September), and fourth quarter (October, November, and December) of 2015 did not include information that the monitoring company/fire department were called to verify the transmission of</p>		<p>documentation that the transmission of the fire alarm signal to the monitoring company occurred and who was spoken to, as well as simulation of emergency conditions. An audit tool has been created and will be completed monthly x 3 months and then quarterly x 2 months to ensure that all requirements are being met. These audit tools will be brought to QA monthly x 3; then quarterly x Q.A. x 2 in order to review for adequacy of documentation and procedure. These systemic changes will be put into place 07/29/2016</p>	

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K 0056 SS=B Bldg. 01	<p>the fire alarm was received. Based on interview at the time of record review, this was acknowledged by the Maintenance Director.</p> <p>3-1.19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 07/21/16 at 9:15 a.m. with the Maintenance Director present, four of four, third shift (night) fire drills were performed between 10:29 p.m. and 12:00 a.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section</p>				

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	<p>9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 steel armover sprinkler pipe observed in the kitchen was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect mostly staff while in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 07/21/16 at 11:05 a.m. during a tour of the facility with the Maintenance Director, one steel sprinkler pipe armover against the north wall of the kitchen was five feet long and was unsupported. This was acknowledged by the Maintenance Director at the time of observation.</p>	K 0056	<p>K056 It is the intent of this facility to comply with all LifeSafety Code Regulations. All residents, visitors and staff have the potential to be affected by a deficiency in this practice. Following LSC Survey, the facility maintenance staff contacted the company responsible for service of the sprinkler system to request placement of the support required on the five foot long sprinkler pipe arm over section. Placement of the support will take place on 08/03/2016. Measures put into place to ensure that this deficiency does not recur: A full facility audit was conducted for any other areas of sprinkler pipe that might be affected and no additional areas of concern were identified. This systemic change will be in place 07/29/2016</p>	07/29/2016			

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K 0130 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 18 of 18 battery powered smoke alarms in resident rooms to ensure the smoke alarms are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on review of the "Battery Check Smoke Detectors" for resident room smoke alarms on 07/21/16 at 10:10 a.m. with the Maintenance Director present, there was no documentation to show all 18 resident room battery powered smoke alarms have had batteries replaced during the past twelve months. Based on interview at the time of record review, the Maintenance Director acknowledged there was no documentation to show all 18 resident room battery powered smoke alarms have had batteries replaced within the past twelve months. Based on</p>	K 0130	<p>K130</p> <p>It is the intent of this facility to comply with all LifeSafety Code Regulations. All residents,staff, and visitors have the potential to be affected by a deficiency in thispractice. Upon completion of the LSCsurvey, the Maintenance Staff replaced all batteries in the battery poweredsmoke immediately and documentation was made toreflect this. Systemic Changes andmeasures put into place to ensure that the deficiency does not recur are: a PMtracking sheet has been initiated with documentation made of the date that allof the batteries in the smoke detectors were changed as required. These tracking sheets will be kept in the LSCBinder in the Administrator's office. These tracking sheets will be reviewed by theMaintenance Director and will be brought to QA quarterly x 5 or untilcompliance is determined adequate in order to ensure that requirements arebeing met and documentation reflects this. This systemic change will bein effect 07/29/2016</p>	07/29/2016

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	observations between 10:30 a.m. and 11:15 a.m. during a tour of the facility with the Maintenance Director, battery powered smoke alarms were observed in all resident sleeping rooms. 3.1-19(b)				