

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
---	---

(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
--------------------	--	---------------	---	----------------------

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: 09/24/15</p> <p>Facility Number: 000338 Provider Number: 155441 AIM Number: 100287590</p> <p>At this Life Safety Code survey, Corydon 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 (222) construction and was fully sprinkled. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38 and had</p>	K 0000		
------------------------	--	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
---	---

(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
--------------------	--	---------------	---	----------------------

K 0025 SS=F Bldg. 01	<p>a census of 28 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 two detached sheds used for facility storage.</p> <p>Quality Review completed 09/29/15 - DA</p> <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 observations and interview, the facility failed to ensure the smoke barriers in 2 of 4 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or</p>	K 0025	<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. K025 - (a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice: (1) The North Hall attic smoke barrier wall has been repaired with</p>	10/24/2015
----------------------------	--	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2015	
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112			
(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			
	<p>be protected by an approved device designed for the specific purpose. This deficient practice affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/24/15 from 11:00 a.m. to 11:30 a.m., the following attic smoke barrier walls had missing drywall and penetrations not firestopped;</p> <p>1. The North Hall attic smoke barrier wall had a one foot by one foot section of drywall missing in the center of the smoke barrier wall and two, one inch gaps around electrical conduit penetration with no fire stopping material used to seal the gaps.</p> <p>2. The South Hall attic smoke barrier wall had a one foot by one foot section of drywall missing in the center of the smoke barrier wall and six, one inch gaps around electrical conduit penetrations with no fire stopping material used to seal the gaps.</p> <p>The North Hall and South Hall attic smoke barrier walls missing drywall and gaps around electrical conduit penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/24/15 at 11:37 a.m.</p>		<p>additional drywall and fire caulking. (2) The south Hall attic smoke barrier wall has been repaired with drywall and fire caulk to fill penetrations around electrical conduit. (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>All residents have the potential to be affected, though none were identified. A facility-wide audit was completed to identify any other non-fire-rated areas.</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: Maintenance director has been in-serviced to the required components of this tag. The standard monitoring and any needed adjustments identified will be done on-site immediately.</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 NHA/Maintenance Director will make rounds to check for any penetrations in fire walls. This will be ongoing. A report of any findings will be discussed at monthly risk management/QA meeting to determine when compliance has been met. This will be completed weekly for three months and then monthly thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
---	---

(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
--------------------	--	---------------	---	----------------------

K 0050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 2 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Records with the maintenance supervisor on 09/24/15 at 9:15 a.m., there was no fire drill documentation for the first shift and second shift, first quarter of the year 2015. Additionally, based on interview with the maintenance supervisor during the review of the Fire Drill Records, there was no other documentation available for review to verify these drills were conducted. This was verified by the maintenance supervisor at the time of</p>	K 0050	<p>K050 –Fire Drills What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The Maintenance Director will conduct fire drills for all three shifts at times that ensure coverage to all staff. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents have the potential to be affected, though none were identified. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance Director has been in-serviced as to the requirements of this tag. Maintenance Director will submit copies of written records of</p>	10/24/2015
----------------------------	--	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2015
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112		
(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	
	record review and acknowledged by the administrator at the exit conference on 09/24/15 at 11:37 a.m. 3.1-19(b)		monthly fire drills to Administrator during monthly QA meetings. 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: The monitoring of this tag will be a joined effort between NHA and Maintenance Director as they review their findings at the monthly Risk Management/QA meeting. This will be an ongoing solution and will be checked by the Director of Plant Operations on quarterly rounds at the facility, to ensure that the facility remains in compliance.		