

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2011
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NAME OF PROVIDER OR SUPPLIER NEW HAVEN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774
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K 000	INITIAL COMMENTS 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: 01/24/11 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, New Haven Care & 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility has a capacity of 120 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as	K 000	<u>Life Safety Inspection Plan of Correction</u> February 4, 2011 This plan of correction is prepared and executed because it is required by the provisions of the state and federal law and not because New Haven Care & Rehabilitation agrees with the allegations and citations listed on pages 1-5 of this statement of deficiencies. New Haven Care & Rehabilitation maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to constitute substandard quality of care or limit our capability to render adequate care. Please accept this Plan of Correction as our credible allegation of compliance. RECEIVED FEB - 7 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
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APPROVED
12-28-2011
2/8/11

Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 01/26/11.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 2-4-11
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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 000 K 056 SS=E	Continued From page 1 evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 4 corridors were equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents at the south nurses' station and near the front reception area. Findings include: Based on observations with the Maintenance Director on 01/24/11 from 1:35 p.m. to 3:20 p.m., the south nurses' station area and the front	K 000 K 056	1) K-056 SS = E If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. 19.3.5 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential of being affected by this practice. The facility is replacing standard response sprinkler heads with quick response sprinkler heads to meet the standard of having the same type of sprinkler heads in a particular smoke compartment. b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential of being affected by this practice. The facility is replacing standard response sprinkler heads with quick response sprinkler heads to meet standard of having consistency of sprinkler heads in a particular smoke compartment.	

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K 056	Continued From page 2 reception area had a mixture of quick response sprinkler heads and standard response sprinkler heads. Based on interview with the Administrator and Maintenance Director, the quick response sprinkler heads were rated 155 degrees Fahrenheit and the standard response sprinkler heads were rated 165 degrees Fahrenheit. 3.1-19(b)	K 056	c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? A vendor has been contracted to install quick response sprinkler heads in the effected areas.		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (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; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1	K 143	d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? The sprinkler system in the facility is inspected on an annual basis to insure that the system is properly functioning. The administrator/designee will report to the QA committee the results of the sprinkler heads being changed from standard to quick response heads for further recommendations if needed. By what date will the systemic changes be completed? Date of compliance – Vendor to begin replacing sprinkler heads referred to in 2567, with work projected to begin 2/14/11. Construction waiver submitted, Anticipated job completion date 2/28/11.		

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K 143 Continued From page 3
hour fire-resistive construction. This deficient practice could affect 1 of 5 smoke compartments.

Findings include:

Based on an observation with the Maintenance Director on 01/24/11 at 2:30 p.m., the oxygen room was completely filled with seven stationary liquid oxygen units and various oxygen cylinders. When asked to demonstrate the transfilling process with a portable unit, CNA # 1 did so while standing with the door open. When asked if this is the way she routinely transfilled the portable unit, she stated usually "the door is open a little".

K 211 SS=B 3.1-19(b)
NFPA 101 LIFE SAFETY CODE STANDARD

Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:

- o The corridor is at least 6 feet wide
- o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
- o The dispensers have a minimum spacing of 4 ft from each other
- o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
- o Dispensers are not installed over or adjacent to an ignition source.
- o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

This STANDARD is not met as evidenced by:

K 143 2) **K-143 SS = E** Transferring of oxygen is 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. 8.6.2.5.2

a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **All residents have the potential of being affected by this practice. The administrator/designee will inspect the oxygen storage room daily x1 week; then bi-weekly times per week x3 weeks; then weekly x5 months, to insure that the room can accommodate one employee with the door closed behind them for the purpose of transferring oxygen.**

K 211 b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? **The administrator/designee will meet with the maintenance director monthly to review the oxygen room log to insure compliance; for the safety of any resident who may potentially be affected.**

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K 211	<p>Continued From page 4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 alcohol based hand sanitizers in the common areas were not installed within a foot of an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents in the North lounge, Physical Therapy gym and the main dining room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 01/24/11 from 1:10 p.m. to 2:10 p.m., alcohol based hand sanitizer dispensers were mounted on the wall above a light switch in the North lounge, above a light switch in the Physical Therapy gym, and above a dimmer switch in the main dining room. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>	K 211	<p>c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</p> <p>Oxygen vendor notified of deficient practice and have agreed to assist facility in correction of deficient practice by allowing sufficient space for staff to enter oxygen room and close door before transferring oxygen.</p> <p>The administrator/designee will meet with the maintenance director monthly to review the oxygen room log to insure compliance; for the safety of any resident who may potentially be affected.</p> <p>The administrator/designee will monitor for compliance monthly with results forwarded to the QA committee for additional interventions if further needs are identified.</p> <p>d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed?</p> <p>The administrator will report to the QA committee the results of audits conducted for further recommendations if needed.</p> <p>The Administrator/designee will monitor for compliance monthly with results forwarded to the QA committee for additional interventions if further needs are identified.</p>	
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By what date will the systemic changes be completed? Date of compliance - 1/24/11.

3) K-211 SS = B Where alcohol based hand rub dispensers are installed in a corridor: Dispensers are not installed over or adjacent to an ignition source.

a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

All residents have the potential of being affected by this practice. The facility will move all dispensers which are installed over or adjacent to an ignition source.

b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?

All residents have the potential of being affected by this practice. The facility will move all dispensers which are installed over or adjacent to an ignition source.

c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?

The facility maintenance director has removed all dispensers which were above or adjacent to a potential ignition source. The facility administrator will inspect the dispensers during daily facility rounds to insure that the deficient practice does not recur.

d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed?

The dispensers have been removed and the facility maintenance director will inspect the dispensers daily during facility rounds x6 months to insure that the deficient practice does not recur.

The maintenance director will report results of daily rounds monthly to the QA committee. If any concerns arise during facility rounds, the maintenance director will report to the QA committee for further recommendations if needed.

By what date will the systemic changes be completed? Date of compliance – 1/31/11