

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/11/2016
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218
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(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: 01/11/16</p> <p>Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900</p> <p>At this Life Safety Code survey, Community 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 two story facility was determined to be of Type II (111) construction and fully sprinklered except for the breakroom phone closet. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in</p>	K 0000	K000 The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation regulation. This providerrespectfully requests that this Plan of Correction be considered the Letter ofCredible Allegation of Compliance and requests a desk review in lieu of a postsurvey on or after 2/3/16.	

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 0048 SS=C Bldg. 01	<p>resident sleeping rooms 133 through 141 and 233 through 237. The facility has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The facility has a capacity of 115 and had a census of 95 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the breakroom phone closet and two detached buildings providing facility storage services which are each not sprinklered.</p> <p>Quality Review completed on 01/13/16 - DA</p> <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 document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire</p>	K 0048	<p>K048 The facility failed to document a complete written healthcare occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·The written fire safety plan will be changed to identify the location of smoke barrier doors and fire</p>	02/03/2016

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	<p>(5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:45 a.m. on 01/11/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. Section E.1a "Fire/Explosion Emergency Action Plan" of the aforementioned written fire safety plan stated "Keep all smoke/fire doors closed". Under Section 1.b "Fire Procedure" states "Continue moving in sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors". Based on interview at the time of record review, the Maintenance Supervisor acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan</p>		<p>doors in the facility for the evacuation of smoke compartments. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·The written plan will be changed to identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. ·Evacuation floor plans will be reviewed and updated to ensure smoke barrier doors are marked appropriately. <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All staff will be in-serviced by the Maintenance Director/Designee on the revised written plan as well as any revisions to the evacuation floor plans by 2/3/16 <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The revised written plan will be placed at each nursing station, the receptionist desk and in the 	

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K 0056 SS=D Bldg. 01	<p>for the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure automatic sprinklers were installed in the breakroom phone closet to provide coverage for all portions of the building. This deficient practice could affect five staff and visitors in the vicinity of the breakroom phone closet.</p>	K 0056	<p>Maintenance office. Each manual will be reviewed and a check list designed to ensure compliance will be completed weekly times 4 weeks and monthly times 5.</p> <p>·If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.</p> <p>By what date will systematic changes be completed?</p> <p>·All systematic changes will be completed by 2/3/16</p> <p>K056</p> <p>The facility failed to ensure automatic sprinklers were installed in the break room phone closet to provide coverage for all portions of the building.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Automatic sprinklers will be</p>	02/03/2016

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 01/11/16, the phone room closet in the breakroom was not sprinklered. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the phone room closet in the breakroom was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>installed in the break room phone closet to provide coverage for all portions of the building.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> -This alleged deficient practice has the potential to affect staff and visitors in the vicinity of the break room phone closet. -Automatic sprinklers will be installed in the break room closet to provide coverage for all portions of the building. <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> -All staff will be in-serviced by the Maintenance Director/Designee on the addition of the automatic sprinkler installed in the break room closet which will provide coverage for that area of the building by 2/3/16 <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> -The revised written plan will be placed at each nursing station, the receptionist desk and in the Maintenance office. Each manual 	

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K 0066 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 2 of 2</p>	K 0066	<p>will be reviewed and a check list designed to ensure compliance will be completed weekly times 4 weeks and monthly times 5.</p> <p>·If threshold of 100% is not achieved, an actionplan will be developed to ensure compliance.</p> <p>By what date will systematic changes be completed?</p> <p>·All systematic changes will be completed by 2/3/16</p> <p>K 066 The facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 2 of 2 outside areas where smoking</p>	02/03/2016

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	<p>outside areas where smoking was permitted. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 01/11/16, the outdoor smoking area located outside the exit door by Room 115 had in excess of 60 extinguished cigarette butts deposited on top of a plastic trash can filled with trash. In addition, the outdoor smoking area located at the ambulance entrance also had in excess of 60 extinguished cigarette butts deposited on top of a plastic trash can filled with trash. A metal container with a self closing cover device into which ashtrays can be emptied were not provided in these areas where staff smoking was taking place. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged extinguished cigarette butts were not deposited into a metal container with a self closing cover device into which ashtrays can be emptied at the two outdoor locations where smoking was taking place.</p> <p>3.1-19(b)</p>		<p>was permitted. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Noncombustible containers with self closing cover devices will be purchased and placed at both locations for depositing cigarette butts. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> This alleged deficient practice could affect all residents, staff and visitors. Any new smoking areas will be equipped with the same noncombustible containers with self closing lids. <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Upon each daily facility walk, Maintenance Director or Designee will check all facility entryways that are designated to have noncombustible containers (i.e., main entry, side entry and reentry) to ensure these areas are equipped with noncombustible containers with self closing lids. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	

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K 0072 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure all means of egress were continuously maintained free of all obstructions or impediments to full instant use on the first floor and second floor. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 01/11/16, resident beds were stored in the</p>	K 0072	<p>program will be put into place? ·The Maintenance Director or Designee willutilize the Life Safety Code CQI tool upon each daily tour. This tool will be completed daily times 4weeks and monthly times 5. ·If threshold of 95% compliance is not achieved,an action plan will be developed to ensure compliance. By whatdate will systemic changes be completed? 2/3/16</p> <p>K 072 Thefacility failed to ensure all means of egress were continuously maintained freeof all obstructions or impediments to full instant use on the first floor andsecond floor. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice? ·Allobstructions will be removed to maintain full instant use on the first andsecond floor. Howwill you identify other residents having the potential to be affected by thesame deficient practice and what</p>	02/03/2016

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	<p>corridor outside Rooms 119, 131, 133, 137 and 139 on the first floor and in the corridor outside Rooms 225, 227, 235 and 237. An upholstered chair was stored in the corridor outside Room 235 on the second floor. Resident Room 127, 128, 132 were noted as being renovated at the time of the observations. In addition, the aforementioned items were noted to be stored in the corridor during the initial walk through of the facility with the Maintenance Supervisor from 9:00 a.m. to 9:20 a.m. Based on interview at the time of the observations, the Administrator stated resident sleeping rooms are being renovated in the facility commencing just after Thanksgiving Day 2015 and acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use on the first and second floor.</p> <p>3.1-19(b)</p>		<p>corrective action will be taken?</p> <ul style="list-style-type: none"> · This alleged deficient practice could affect all residents, staff and visitors. · An audit utilizing the Life Safety Code CQI tool will be conducted by the Maintenance Director or Designee to identify obstructions or impediments to full instant use on the first floor and second floor. · This audit will be conducted by 2/3/16. <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Maintenance Director will ensure that any new obstructions that get placed in the path of egress are removed. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · The Maintenance Director or Designee will utilize the Life Safety Code CQI tool upon each daily tour to ensure all paths for egress on the first and second floors are clear to maintain full instant use. This tool will be completed daily times 4 weeks and monthly times 5. · If threshold of 95% compliance is not achieved, an action plan will be developed to ensure compliance. <p>By what date will systemic changes be completed?</p> <p>2/3/16</p>	

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K 0103 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure interior walls in 1 of over 60 rooms in the facility were comprised of noncombustible or limited combustible materials. LSC 19.1.6.3 states all interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited combustible materials.</p> <p>Exception: Listed, fire retardant treated wood studs shall be permitted within non-load bearing 1-hour fire rated partitions.</p> <p>This deficient practice could affect five staff and visitors in the vicinity of the breakroom phone closet.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 01/11/16, wood studs comprised the frame of the phone room closet non-load bearing interior wall in the breakroom. The wall measured eight feet high by ten feet wide and consisted of a wood frame and drywall on the breakroom side of the</p>	K 0103	<p>K 103 The facility failed to ensure interior walls in 1 of over 60 rooms in the facility were comprised of noncombustible or limited combustible materials.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> The interior walls that were not comprised of noncombustible materials will be replaced with noncombustible or limited combustible materials. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> This alleged deficient practice could affect 5 staff and visitors in the vicinity of the break room phone closet. An audit will be conducted on or before 2/3/16 by the Maintenance Director or designee utilizing a facility bed board to identify if there are other rooms in the facility that could potentially be comprised of noncombustible or limited combustible materials. <p>What measures will be put into place or what systematic changes you will make</p>	02/03/2016
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	wall. Based on interview at the time of observation, the Maintenance Supervisor stated he was unaware of the fire retardant status of the studs, no other fire retardant documentation for the wood studs was available for review and acknowledged documentation for the aforementioned non-load bearing interior wall frame was not available for review to show the wall was comprised of noncombustible or limited combustible materials. 3.1-19(b)		<p>toensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Toensure that this alleged deficient practice does not recur, any new interiorwalls that are erected will be built with noncombustible or limited combustiblematerials ·MaintenanceDirector will ensure that any future interior walls that are built will beequipped with noncombustible materials. <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i e, what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The MaintenanceDirector or Designee will utilize the Life Safety Code CQI tool to ensure any new interior walls that are erected willbe built with noncombustible or limited combustible materials. This tool will be completed weekly times 4weeks and monthly times 5. ·If threshold of 100% compliance is not achieved,an action plan will be developed to ensure compliance. <p>By whatdate will systemic changes be completed? 2/3/16</p>	