

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2014
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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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K010000	<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: 04/04/14</p> <p>Facility Number: 000388 Provider Number: 155807 AIM Number: 100454140</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rural Health Care 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 V (000) construction and was fully sprinklered. 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 all resident</p>	K010000	<p>This plan of correct is to serve as Rural Health Care's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rural Health Care or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
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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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	<p>sleeping rooms. The facility has a capacity of 50 and had a census of 43 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 one detached wooden shed providing facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010025 SS=E	<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 observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or 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 be protected by an approved device designed for the specific purpose. This deficient practice could affect twenty residents, staff and visitors in the Dining Room if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14,</p>	K010025	<p>It is the policy of Rural Health Care to attain and maintain compliance of K025.I. The one inch annular space surrounding each of five holes for the passage of nine conduits were filled with a material designed to maintain smoke resistance.II. The deficient practice has the potential to affect 20 residents, staff members and visitors. A facility audit was conducted to identify any other potential residents, staff members and family members that could be affected with none noted.III. The Maintenance Supervisor will conduct rounds to ensure that the smoke barriers remain in place. The Maintenance Supervisor will repair or replace smoke barriers as needed.IV. The Administrator or his supervisor will conduct rounds to ensure that the smoke barriers remain in tact.</p>	05/02/2014			

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	<p>the one inch annular space surrounding each of five holes for the passage of nine conduits were noted in the ceiling smoke barrier above Electrical Panel B in the dietary storage area near the south exit. Based on interview at the time of observation, the Administrator acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>			
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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 6 of 6 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 10:00 a.m. to 1:10 p.m. and 2:20 p.m. to 3:10 p.m. on 04/04/14, documentation of functional testing for not less than 30 seconds for six of six battery operated emergency lights for the most recent twelve month</p>	K010046	<p>It was the practice of Rural Health Care to maintain compliance of K046. I. The Maintenance Supervisor will maintain records showing that the six battery powered emergency lights have been tested monthly not less than 30 seconds and not less that 90 minutes annually. II. This practice could affect all residents and guest in the facility. III. A audit tool will be put in place to show the date that each emergency light was tested and for how long. There will be an area on the tool to show the annual 90 minute test. The Maintenance Supervisor will keep these records in a binder that will be readily available for review. The Maintenance Supervisor will be inserviced on K046. IV. The Administrator or his designee will review the audit tool monthly for 6 months and quarterly thereafter to ensure that the Maintenance is keeping record of the emergency lighting tests.</p>	05/02/2014			

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	<p>period was not available for review. In addition, documentation of an annual test for six of six battery powered emergency lights for not less than 1 ½ hour duration for the most recent twelve month period was not available for review. Based on observations with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14, a total of six battery operated emergency lights were located in the facility and each battery operated emergency light operated when their respective test button was pushed. Based on interview at the time of record review and of the observations, the Administrator acknowledged six battery operated emergency lights were located in the facility, documentation of monthly functional testing for not less than 30 seconds and documentation of an annual ninety minute test for the most recent twelve month period for each battery operated emergency light was not available for review.</p> <p>3.1-19(b)</p>				

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K010050 SS=F	<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 document fire drills conducted on the first, second and third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" with the Administrator during record review from 10:00 a.m. to 1:10 p.m. on 04/04/14, documentation of a fire drill conducted on the first, second and third shift for the first quarter of 2014 was not available for review. Based on interview at the time of review, the Administrator stated no other fire drill documentation was available for review and acknowledged documentation of a fire drill conducted on the first, second and third shift for the first quarter of 2013 was not available for review.</p>	K010050	<p>It is the practice of Rural Health Care to maintain compliance of K050. I. The Maintenance Supervisor will conduct fire drills at least quarterly on each shift. II. This deficient practice has the potential to affect all residents, staff and visitors. III. The Maintenance Supervisor will be inserviced on K050, its interpretation and how he will ensure that the facility conducts fire drills to maintain compliance of K050. The Maintenance Supervisor will document the dates and times of fire drills conducted and keep the documentation readily available for review. IV. The Administrator or his designee will check the documentation quarterly to ensure that the documentation is being properly maintained.</p>	05/02/2014			

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	3.1-19(b)			
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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 8 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. Fire extinguishers passing the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 inches by 3 1/2 inches. The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:</p> <p>(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch.</p> <p>(b) Name or initials of person performing the maintenance and name of agency performing the maintenance.</p> <p>NFPA 10 at Section 4-4.4.2, Verification of Service (Maintenance or Recharging) requires each extinguisher that has</p>	K010064	<p>It is the policy of Rural Health Care to maintain compliance of K064. I. The facility will have the indicated fire extinguisher outside room 21 replaced with another extinguisher that meets the standards in K064. The portable extinguisher in the maintenance off ice will also be checked monthly. II. This deficient practice has the potential to affect 3 staff members and visitors in the vicinity of the maintenance office. III. The Maintenance Supervisor will conduct monthly inspections to ensure that each extinguisher and initial and date the tags. IV. The Administrator or his designee will conduct random checks to ensure that the fire extinguishers have been inspected.</p>	05/02/2014
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	<p>undergone maintenance that includes internal examination or has been recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. This deficient practice could affect 30 residents, staff and visitors in the vicinity of Room 21.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14, the portable fire extinguisher in the corridor outside Room 21 was manufactured in 1994 and had an affixed label stating the most recent documented six year maintenance procedures were performed in February 2000. A verification of service collar was not located around the neck of the container. Based on interview at the time of observation, the Administrator</p>						

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	<p>acknowledged it had been more than six years since the most recent six year maintenance procedures had been performed and no verification of service collar was affixed to the aforementioned portable fire extinguisher.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to inspect 1 of 8 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect three staff and visitors in the vicinity of the Maintenance Office.</p> <p>Findings include:</p>			
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	<p>Based on observation with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14, the annual maintenance tag attached to the portable fire extinguisher in the Maintenance Office by the Laundry indicated monthly inspections had not been documented for January, February and March 2014. Based on interview at the time of observation, the Administrator stated no other monthly Maintenance Office fire extinguisher inspection documentation was available for review and acknowledged monthly inspections for the aforementioned portable fire extinguisher were not documented for January, February and March 2014.</p> <p>3.1-19(b)</p>				

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K010072 SS=E	<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 Based on observation and interview, the facility failed to ensure 2 of 3 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 30 residents, staff and visitors if needing to exit the facility by the northeast and southeast exits.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14, the following was noted:</p> <p>a. a five foot high by three feet wide by eighteen inches deep metal storage cabinet was stored in the corridor outside Room 25 near the northeast exit which is marked with an exit sign.</p> <p>b. a six foot high by three foot wide by eighteen inch deep plastic storage cabinet was stored in the corridor outside Room 16 near the southeast exit which is marked with an exit sign.</p> <p>c. a three foot high by two feet wide by</p>	K010072	It is the policy of Rural Health Care to maintain compliance of K072.I. The storage cabinets and shred box were removed.II. The deficient practice has the potential to affect 30 residents, staff members and visitors. The facility was inspected to ensure there were no other storage cabinets or shred boxes in the hallways that could affect anymore residents, staff members or visitors with none noted.III. The Maintenance Supervisor will conduct daily rounds to ensure that the facility's egresses remain free of obstructions.IV. The Administrator or his designee will conduct rounds to ensure that the facility's egresses remain free of obstructions.	05/02/2014			

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	<p>two feet deep wooden paper shredder was stored in the corridor outside Room 18 and in the corridor by the Nurses Station. Based on interview at the time of the observations, the Administrator acknowledged the northeast and southeast exits are marked with an exit sign as facility exits but each means of egress was not maintained free of all obstructions to instant use.</p> <p>3.1-19(b)</p>			
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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99,</p>	K010144	<p>It is the policy of Rural Health Care to maintain compliance of K0144. I. The facility will conduct monthly load test in specifications to K0144.II. The deficient has the potential to affect all residents, staff members and visitors of the facility.III. The Maintenance Supervisor will conduct the monthly tests for 30 minutes. The Maintenance Supervisor will maintain proper documentation verifying the test was conducted per K0144. IV. The Administrator or his designee will randomly check the Maintenance Supervisor's documentation to ensure that the generator load test was conducted and properly documented.</p>	05/02/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155807		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/04/2014	
NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218			
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	<p>3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Preventive Maintenance" documentation with the Administrator during record review from 10:00 a.m. to 1:10 p.m. and 2:20 p.m. to 3:10 p.m. on 04/04/14, documentation of monthly load testing for January, February and March 2014 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of monthly load testing for January, February and March 2014 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 12 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical</p>						

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	<p>systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Preventive Maintenance" documentation with the Administrator during record review from 10:00 a.m. to 1:10 p.m. and 2:20 p.m. to 3:10 p.m. on 04/04/14, documentation of weekly inspections of the starting batteries for the emergency generator for the twelve week period of 01/01/14 through 03/31/14 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of weekly inspections of the starting batteries for the emergency</p>			
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	generator for the twelve week period of 01/01/14 through 03/31/14 was not available for review. 3.1-19(b)			

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> 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 <p>Based on observation and interview, the facility failed to ensure 3 of over 23 alcohol based hand sanitizers were not installed above an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 1:10 p.m. to 2:20 p.m. on 04/04/14, an alcohol based hand sanitizer was observed installed within one inch of an electrical outlet in the bathroom in Room</p>	K010211	<p>It is the practice of Rural Health Care to maintain compliance of K0211.I. The hand sanitizers were moved to ensure they were not near an ignition source.II. The deficient practice had the potential to affect 30 residents, staff members and visitors. A facility audit was conducted to identify any other residents, staff members and visitors that could be affected with none noted.III. The Maintenance Supervisor will ensure that all hand sanitizers that are installed in the future are not adjacent to an ignition source.IV. The Administrator or his designee will conduct random rounds to ensure that there are no hand sanitizers adjacent to an ignition source.</p>	05/02/2014
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	<p>18, Room 24 and Room 26. Each of the aforementioned hand sanitizer's contained propylene glycol as an ingredient as stated on its packaging. Based on interview at the time of the observations, the Administrator acknowledged the aforementioned hand sanitizers were alcohol based and were installed adjacent to an ignition source.</p> <p>3.1-19(b)</p>			
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